

LADY HEALTH WORKERS IN PAKISTAN:  
TRACING PERSONAL AND PROFESSIONAL  
TRAJECTORIES WITHIN A PATRIARCHAL  
CONTEXT

CHAUDHRY MUHAMMAD AMJAD

A thesis submitted in partial fulfillment of the  
requirements for the degree of  
Doctor of Philosophy

QUEEN MARGARET UNIVERSITY

2019

## Abstract

In Pakistan, the Lady Health Workers (LHWs) a cadre of Community Health Workers (CHWs) are providing health services to communities in rural areas and disadvantaged urban area since 1994. Introduced to enhance women's access to PHC, they countered gender barriers of segregation and restrictions on the mobility of women. Currently 100,000 LHWs are deployed in the country. The LHW have been granted the status of regular government employees recently following nationwide campaign including protests. Generally the interest in the LHWs has been largely confined to monitoring and evaluation of their activities. The perspectives of LHWs as a female workforce on the margins of formal health system within a patriarchal context, has never been explored. This qualitative study was designed with the aim to explore and describe how the experiences of the LHWs shape the process of their development as female health workers in the Pakistani health system. The three objectives of the study were to explore how the LHWs' life and work experiences influenced their development as health workers, to examine the process by which LHWs constructed and defined their personhood and to understand how community- and workplace-based gender dynamics influenced the LHWs in the Pakistani health system. This qualitative study was carried out two in four union councils of a district in Pakistan. It involved 32 indepth interviews conducted with 27 LHWs, while six FGDs were conducted with this cadre of women. Interviews were also conducted with other health professionals including eight health managers, two medical assistants, two Lady Health Visitors (LHVs), three Lady Health Supervisors (LHSs) and three Vaccinators. The results showed that both community and health system were important contexts for the LHWs' socialisation and formation of professional identity. The transitions, turning points and trajectories of the LHWs show that the LHWs have used their agency to make the best use of available resources and are proud of their achievements. The analysis of findings gave useful insights about the practices which led to the development of identity through professional socialisation process. Gender was pervasive in all spheres of personal and professional lives of the LHWs, and lack of health system support such as referral rendered the LHWs' services ineffective. The LHWs attributed community health improvement to their contributions, and identified with the government health team after regularisation.

## **Declaration**

I hereby declare that this submission is my own work and that, to the best of my knowledge, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree of the university or other institute of higher learning, except where due acknowledgement has been made in the text.

## **Acknowledgements**

I would like to thank and offer my sincerest gratitude to my supervisor, Dr.Karina Kielmann for supporting me throughout my very long journey. Her patience, encouragement and support enabled me to reach my destination. She kept her faith in me throughout, and her encouragement made it possible for me to complete this thesis. I would also like to thank my supervisor Professor Alastair Ager for his support and advice. In the formative stages, I was lucky to benefit from my previous supervisors Professor Barbara McPake, Jean Robson and Oonagh O'Brien and am grateful for their kind support. I also offer thanks to the entire staff at IGHD for their help and advice at every stage. My sincere thanks to Kyoko Jardine and Janice Burr, for always being there for me, and helping me out in the hour of need. My fellow students at IGHD were always a source of encouragement for me.

My special thanks to Dr.Nina Talbot, my GP in Edinburgh, for her medical advice and concern for my health during the most stressful times of my life.

I am thankful to the District Health Department in Pakistan, their staff and especially the Lady Health Workers who participated in my study. Without their cooperation, this study would not have been possible.

Finally, I would like to thank my wife Juneda, and my children Ali, Ahmed and Salma for their patience. I am thankful to my family members in Islamabad, Glasgow and Canada for their prayers and well wishes throughout the course of studies.

## **Dedication**

**Dedicated to the Lady Health Workers of Pakistan**

## **Acronyms and Abbreviations**

ASHA:	Accredited Social Health Activist
BHU:	Basic Health Unit
CHW:	Community Health Workers
CMW:	Community Midwives
CoP:	Communities of Practice
EPI:	Expanded Programme on Immunisation
FGD:	Focus Group Discussion
ILO:	International Labour Organisation
LHS:	Lady Health Workers' Supervisor
LHV:	Lady Health Visitors
LHW:	Lady Health Workers
MA:	Medical Assistant
MCH:	Maternal and Child Health
MMR:	Maternal Mortality Ratio
NID:	National Immunisation days
NP:	National Programme for Family Planning and Primary Health Care
PHC:	Primary Health Care
RHC	Rural Health Centre
TBA	Traditional Birth Attendant
WHO	World Health Organisation

## Table of contents

Acronyms and Abbreviations .....	6
List of Tables.....	11
List of Figures .....	12
List of Annexes.....	13
Chapter I.....	14
1.1 Introduction .....	14
1.2 The healthcare delivery system of Pakistan .....	17
1.3 Status of maternal and child health .....	18
1.4 The introduction of the NP into Pakistan.....	19
1.5 Recent developments in the NP .....	23
1.6 Aim .....	25
1.7 Objectives .....	25
1.8 Organisation of the thesis .....	25
Chapter II .....	27
Literature Review .....	27
2.1 Overview .....	27
2.2 Community Health Workers: a historical trajectory.....	28
2.2.1 Evolution of Primary Health Care.....	28
2.2.2 Approaches to Primary Health Care .....	29
2.2.3 Perspectives on CHWs based Community Oriented Programmes .....	32
2.3 Community Health Workers .....	34
2.3.1 Nomenclature and definition of a CHW .....	34
2.4 CHWs whether agents of change or service extenders.....	40
2.5 CHWs' Motivation .....	45
2.6 Context and performance .....	48
2.6.1 The significance of contextual factors.....	49
2.6.2 Social context of female health workers - Role of Patriarchy.....	51
2.6.3 Conceptualising Gender.....	53
2.6.4 Gender division of labour .....	56
2.6.5 Intra household bargaining .....	57
2.6.6 Gender norms seclusion and mobility a reflection of patriarchy .....	58
2.7 Socio/cultural context Pakistan and South Asia .....	59
2.7.1 Social context of female healthcare workers .....	60
2.8 Health System challenges: supervision and motivation .....	62
2.8.1 Supervision.....	62
2.8.2 Motivation .....	64
2.9 CHWs' work practices .....	66
2.9.1 Changes in Community Health Workers .....	67
2.10 Positioning of the LHW.....	71
2.10.1 Intermediary .....	71
2.10.2 Bridge between community and health centres .....	72
2.10.3 Agents of change.....	73
2.10.4 Integration into formal health systems .....	74

2.11 Socialisation/Professional socialisation.....	75
2.12. Development of professional identity of health workers .....	78
2.12.1 Identity .....	78
2.12.2 Professional identity .....	79
2.13 Life course Perspective.....	81
2.14 Gaps in research .....	81
2.15 Conceptual framework .....	82
<b>Chapter III.....</b>	<b>86</b>
<b>Methodology .....</b>	<b>86</b>
3.1 Introduction .....	86
3.2 Philosophical assumptions and theoretical underpinnings .....	87
3.2.1 Epistemological concerns .....	90
3.3 Reflections on the overall research process .....	92
3.4 Choosing Qualitative Research .....	93
3.5 My reflexive positioning during the course of the study .....	95
3.6 Reflexivity .....	96
3.7 Study Methodology.....	97
3.7.1 Study Design .....	97
3.7.2 Study Area .....	97
3.7.3 Study Population .....	101
3.7.4 Research Participants .....	101
3.7.5 Sampling Process.....	102
3.7.6 Sample size .....	103
3.8 Ethical considerations .....	105
3.8.1 Trust and confidentiality .....	105
3.8.2 Cultural norms and values .....	106
3.8.3 Obtaining informed consent .....	107
3.9. Data Collection Methods.....	107
3.9.1 Interviews.....	108
3.9.2 FGDs.....	108
3.9.3 Rationale for choice of methods: Interviews and focus group discussions.....	109
3.9.4 Process of data collection .....	110
3.9.5 Data collection topic guides .....	112
3.9.6 Language and translation issues .....	112
3.10 Data organisation and management .....	113
3.11 Data analysis .....	113
3.12 Conclusion.....	116
<b>Chapter IV .....</b>	<b>117</b>
<b>The Lady Health Workers in the making.....</b>	<b>117</b>
4.1 Introduction .....	117
4.2 LHWs: The immediate context .....	118
4.3 Introducing LHWs .....	120
4.3.1 Mehtab: quest for survival .....	120
4.3.2 Khalida: A pioneer LHW .....	122
4.3.3 Sughra: LHW with an ambition .....	123



4.3.4 Nasreen: Mastering life and work skills .....	125
4.4 Education and early career aspirations of LHWs .....	128
4.5 Looking for job seekers? .....	131
4.6 Why join as a health worker? .....	134
4.6.1 Majboori.....	135
4.6.2 Khidmat: Serving the community.....	138
4.6.3 Shauk: The interest to do something .....	139
4.7 Conclusion.....	141
<b>Chapter V .....</b>	<b>145</b>
<b>Historical context and perspectives .....</b>	<b>145</b>
5.1 Introduction .....	145
5.2 LHWs as new players in the health system .....	146
5.3 Breaking the mould: The search for female health workers .....	148
5.4 Paving the way: Men as household gatekeepers .....	151
5.5 Health workers' training needs and modalities .....	156
5.6 Training the LHWs .....	158
5.7 Introduction of the NP: The organisational challenges .....	159
5.8 Conclusion.....	163
<b>Chapter VI.....</b>	<b>166</b>
<b>Professional socialization: Pathway to a transformative change .....</b>	<b>166</b>
6.1 Introduction .....	166
6.2 Training of the LHWs: Experiences and concerns around learning .....	167
6.3 Venturing into the field; making inroads into the community .....	174
6.4 Being chaperoned: Coping with mobility in the community .....	181
6.5 'Loafing' around: The challenge of home visits.....	183
6.6 Mothers-in-laws: Gatekeepers of traditions.....	185
6.7 <i>Dais</i> : Custodians of women's health in their communities .....	187
6.8 Dilemma of men in communities: to engage or disengage .....	189
6.9 Community embeddedness: An advantage for health workers.....	192
6.10 Building LHWs relations from individual to collective.....	194
6.11 Transformative changes in the LHWs.....	197
6.12 <i>Izzat</i> and respect.....	201
6.13 Trust .....	204
6.14 Conclusions .....	206
<b>Chapter VII.....</b>	<b>210</b>
<b>Situational ownership: From induction to integration.....</b>	<b>210</b>
7.1 Introduction .....	210
7.2 Extenders of health services: Contribution of the LHWs in communities .....	211
7.3 LHWs as a lynchpin in vaccination activities.....	214

7.4 Challenges in forging referral links .....	218
7.5 <i>Dais</i> : Custodians of women's health in their communities .....	223
7.6 The burden of multitasking .....	226
7.7 Acquiring further skills: Over and above the "Call of Duty" .....	228
7.8 Coping strategies for work-life balance .....	233
7.9 LHWs as gatekeepers of household spending .....	236
7.10 Conclusion .....	239
<b>Chapter VIII .....</b>	<b>243</b>
<b>LHWs' quest for identity .....</b>	<b>243</b>
8.1 Introduction .....	243
8.2 Embracing a health worker's identity: The emergence of LHWs.....	244
8.3 LHWs identity as family planning facilitators: An inherent conflict.....	246
8.4 Recognition as a <i>Baji</i> .....	248
8.5 Recognition as doctors .....	250
8.6 LHWs status and positioning within health centres .....	252
8.7. The struggle for a new identity: Legitimising LHWs as government employees.....	257
8.8 There's many a slip 'twixt the cup and the lip: Apprehensions on regularisation .....	266
8.9 Conclusions .....	271
<b>Chapter IX .....</b>	<b>275</b>
<b>Discussion.....</b>	<b>275</b>
9.1 Introduction .....	275
9.2 Primary Motivation for the LHW.....	275
9.3 Transitions and Turning Points .....	276
9.4 Transformation through Professional Socialisation .....	277
9.5 Gender aspects of a gendered workforce.....	278
9.6 Gendered barriers .....	279
9.7 Forging a new Identity over time .....	280
9.8 Transitions .....	283
9.9 Situational ownership.....	283
9.10 Linkages and Referral.....	284
9.11 Individual to Collective Agency (Activism).....	286
9.12 Agents versus extenders .....	287
9.13 Organizational hierarchy.....	288
9.14 Recommendations for policy and practice .....	288
9.15 Limitations of the study .....	290
9.16 Contribution in knowledge .....	291
9.17 Areas for further research .....	291
9.18 Conclusion .....	292
<b>10. Bibliography .....</b>	<b>294</b>

## **List of Tables**

<b>Table No. 1.1 Maternal and child health services in Pakistan</b>	<b>Page 19</b>
<b>Table No. 2.1 Selective versus Comprehensive approaches Primary Health Care</b>	<b>Page 31</b>
<b>Table No. 2.2 Titles of Community Health Workers</b>	<b>Page 35</b>
<b>Table No. 2.3 Types and characteristics of Community Health Workers</b>	<b>Page 36</b>
<b>Table No. 2.4 CHWs as agents of change vs. extension agents</b>	<b>Page 44</b>
<b>Table No. 3.1 Details of LHWs and the health facilities</b>	<b>Page 104</b>
<b>Table No. 3.2 Details of LHWs and the health facilities</b>	<b>Page 104</b>
<b>Table No. 3.3 Phasing of data collection</b>	<b>Page 111</b>
<b>Table No 3.4 Analytic dimensions and attributes of LHWs</b>	<b>Page 115</b>

## **List of Figures**

<b>Figure 1.1 Organization of the public healthcare system in Pakistan</b>	<b>Page 18</b>
<b>Figure 1.2 Organisation of the NP in Pakistan</b>	<b>Page 21</b>
<b>Figure 2.1 Categorising CHWs by pre-service training and remuneration</b>	<b>Page 36</b>
<b>Figure 2.2 Framework of CHW transactional social process</b>	<b>Page 50</b>
<b>Figure 2.3 Conceptual framework for the study</b>	<b>Page 84</b>
<b>Figure 3.1 Map of study area</b>	<b>Page 99</b>
<b>Figure 4.1 Educational levels of LHWs included in study</b>	<b>Page 119</b>
<b>Figure 4.2 Reasons to join as LHWs</b>	<b>Page 144</b>
<b>Figure 5.1 Organization of the District Health System</b>	<b>Page 159</b>
<b>Figure 5.2 Organization of the District Health System after NP introduction</b>	<b>Page 162</b>
<b>Figure 5.3 Organizational relationships of the NP in the District Health System</b>	<b>Page 163</b>
<b>Figure 6.1 Socialization and transformation of the LHWs</b>	<b>Page 207</b>
<b>Figure 7.1 Web of interrelationships of socialization, practices and identity of LHWs</b>	<b>Page 242</b>
<b>Figure 8.1 Evolution of the LHW identity</b>	<b>Page 273</b>
<b>Figure 8.2 LHWs life trajectories path towards an identity</b>	<b>Page 274</b>

## **List of Annexes**

<b>Annex 1 Ethical approval Queen Margaret University</b>	<b>Page 312</b>
<b>Annex 2 Information Sheet for Interviews of Lady Health Workers Information Sheet for Potential Participants</b>	<b>Pages 313-14</b>
<b>Annex 3 Information Sheet for Interviews of Lady Health Workers Information Sheet for Potential Participants Urdu Version</b>	<b>Pages 315-16</b>
<b>Annex 4 Information Sheet for Focus Group Discussion of Lady Health Workers</b>	<b>Pages 317-18</b>
<b>Annex 5 Information Sheet for Focus Group Discussion of Lady Health Workers Urdu Version</b>	<b>Pages 319-20</b>
<b>Annex 6 Information Sheet for Key Informants</b>	<b>Pages 321-22</b>
<b>Annex 7 Information Sheet for Key Informants Urdu Version</b>	<b>Pages 323-24</b>
<b>Annex 8 Consent Form for Lady Health Worker Interview</b>	<b>Page 325</b>
<b>Annex 9 Consent Form for Lady Health Worker Interview Urdu Version</b>	<b>Page 326</b>
<b>Annex 10 Consent Form for Lady Health Worker participant of focus group discussion</b>	<b>Page 327</b>
<b>Annex 11 Consent Form for Lady Health Worker participant of focus group discussion Urdu Version</b>	<b>Page 328</b>
<b>Annex 12 Consent Form for Key informant Interview</b>	<b>Page 329</b>
<b>Annex-13 Consent Form for Key informant Interview Urdu Version</b>	<b>Page 330</b>
<b>Annex 14 Sample topic guide of potential areas of inquiry for Interviews</b>	<b>Page 331</b>
<b>Annex 15 Sample topic guides potential areas of inquiry for FGDs</b>	<b>Page 332</b>
<b>Annex 16 Field guide for Key Informants</b>	<b>Page 333</b>
<b>Annex 17 Field guide for Lady Health Workers Interviews</b>	<b>Page 334</b>
<b>Annex 18 Field guide for Lady Health Workers Focus Group Discussions</b>	<b>Page 335</b>

# Chapter I

## 1.1 Introduction

This qualitative study focuses on Lady Health Workers (LHWs), an exclusive female cadre of Community Health Workers (CHWs) in Pakistan, a country facing acute shortages of human resources in healthcare (WHO, 2006). The interviews and Focus Group Discussions (FGDs) for this research were conducted during the fieldwork in Pakistan in the study area from December, 2013 to July 2014. Pakistan has one of the lowest densities of health workers in the region and globally (WHO, 2017), and less than the required threshold necessary to achieve universal health coverage (WHO, 2016). Introduced in poor rural and urban areas by the National Programme for Family Planning and Primary Health Care<sup>1</sup> (NP) in 1994, these health workers were expected to mitigate contextual barriers and enhance women's access to health services. Currently, the number of LHWs in the country exceeds 100,000 and they are providing basic health services to the households in their catchment areas (Planning Commission, 2010).

The LHWs working in the NP can be considered as an example of the CHWs envisioned by WHO within the social setting of the health system (WHO., 1989). Unlike other facility-based health workers, LHWs are socialised at the crossroads of communities and the healthcare system, which shapes their professional trajectories and personal identities as health workers. They work closely with the Primary Health Care (PHC) centres, which, in the South Asian context, have been alluded to as “a social system embedded in medical culture and responsive to an encompassing regional social structure” (Nichter, 1986, p. 347).

In Pakistan, the overarching social structure provides a highly patriarchal context, within which the gendered roles of LHWs are embedded. More broadly, the gendered experience of Pakistani women is shaped by historical, socioeconomic and ethnic factors (Donnan, 1997). This leads to differentials in access to resources for women

---

<sup>1</sup> Formerly named as Prime Minister's Programme for Family Planning and Primary Health Care

(Winkvist and Akhter, 2000). The gender-specific roles and available choices for women place them at a disadvantage (Fikree and Pasha, 2004), primarily because of their segregation and confinement to home (Khan, 1999, Shaikh et al., 2008).

This study examines the personal and professional trajectories of the LHWs, a gendered work force, and explores how their socialisation within the Pakistani health system affected their integration and working practices within the health system. In light of a renewed interest in community health workers (Bangdiwala, 2011, Haines et al., 2007b, WHO, 2010a), the LHW programme in Pakistan provides a lens to address a broader question of central importance to global public health, namely: How and to what extent are female lay health workers able to develop a professional identity to improve women's access to health services within patriarchal settings?

The focus of my research was on the issues of LHWs and their development in the microcosm of the district. However, when my study was being conducted a lot of changes were taking place within the NP which greatly affected the LHWs' position within the health system. These women have come a long way from being housewives to health workers fighting for their rights. Despite representing a sizeable female workforce working for more than two decades in a patriarchal setting, interest in the NP has almost exclusively been confined to evaluating the LHWs' performance by measuring the outputs. Despite their significant numbers and distinction from other health professionals, the LHWs are often an overlooked health workforce. Their own perspective, as a workforce on the margins of the health system, remains largely unaddressed. Improving our understanding of their perspective is imperative for providing them with an enabling environment, especially as they actually constitute an integral part of the formal health system (Schneider and Lehmann, 2010).

Most of the studies focusing on CHWs report short-term projects, therefore, issues of long term socialisation and negotiation of their identities remain largely unaddressed. LHWs are positioned on a spectrum, ranging from intermediary to agents of change, often placed somewhere in the middle as a bridge between community and formal health care system. After more than two decades in the field, the LHWs have socialised within their profession and as a result are expected to have developed one

or more identities. Development of professional identity as a result of LHWs' practices in the field and professional socialisation process are unexplored areas of research. The knowledge of professional socialisation and identity of LHWs as a community-based workforce can help unpack how their effectiveness is hampered or enhanced by the existing social stratifications, especially those based on gender. LHWs' position as female health workers in communities may have enabled them to challenge some aspects of the pervasive gender system that determines the women's level of autonomy and work differentials (Khan, 2011a). Their capacity to bring about change in their communities may, however, be limited by their own position as women, and their conformity to gender ideals in the communities. Working in communities that represent and adhere to societal norms, they consequently present a particularly interesting twist to the question of how social context constrains or enhances the development of this workforce and its ability to perform tasks?

The individual and group experiences of LHWs within the health system shape their social as well as their professional identity. In this study, I seek to explore the transition LHWs underwent, from entering the NP as novices to their present positioning as community-based health workers. This transition entailed acculturation and a change process whereby new values and norms were internalised, leading to a professional identity and personal trajectory that consequently affected their participation and practices as health workers. Though not classified as health professionals, these women's role and status instils some semblance of professional personhood in them, which, in turn, may also affect their motivation and performance. Up until now the LHWs have only been evaluated for their performance, with no consideration of how their personal and professional lives progress, for both of these have a direct impact on the services they provide to the community at grass root level as well as their own career development. This study aims to trace these trajectories in order to enhance the overall understanding of this workforce which offers a huge potential in health gains through preventive and some curative services in a resource constrained country like Pakistan.

Generally Pakistan is a conservative society, and women live in a protective environment. Being patriarchal, the Pakistani society places restrictions on women's



movement outside their homes. The stereotypical role of women is delineated by the concept of *chadar aur char dewari*, i.e. the concealment and confinement within the four walls of the house defines a woman's social space and relationships within her community. These restraints are determined by the prevalent social and religious norms culminating in different forms of the segregation of the sexes and in the observation of purdah. These norms also have their bearing on women working for a living, for women are culturally regarded not as breadwinners, but as homemakers. The LHW's job can be a double edged sword, for on one hand they are expected to improve the health access of women in their communities, while on the other they have to negotiate their own position within their homes, health centres and society at large.

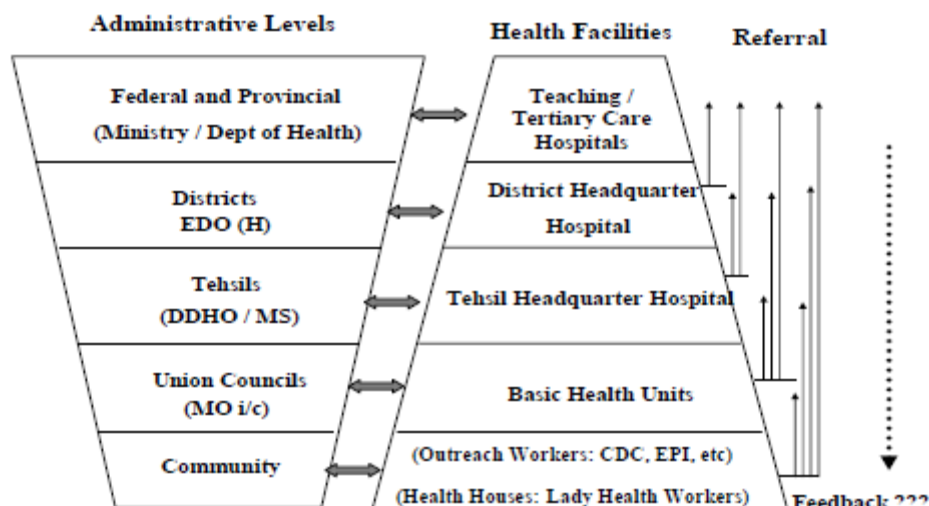
## **1.2 The healthcare delivery system of Pakistan**

Pakistan's public-sector healthcare system is three-tiered, comprising primary, secondary and tertiary level healthcare facilities. The private health sector is large, primarily for-profit and still mainly unregulated. The Federal Ministry of Health and provincial health departments implement many health programmes, including those focusing on maternal and child health (MCH). At the federal level, the health ministry played an important role in policy and planning, inter-province coordination, liaising with international agencies and the provision of health services. The provincial health departments also perform some of these functions at the provincial level. However, the main impetus is on the implementation of programmes, including monitoring and evaluation. The provinces also manage the medical and nursing educational institutions and the provision of health services. The districts are more involved in healthcare delivery and preventive programmes at and below the district levels within health centres. In the year 2000, many functions were devolved to the districts.

Pakistan has 1,201 Hospitals, 683 Rural Health Centres, 5,518 Basic Health Units and 5,802 dispensaries in the public sector. However, the public system has remained chronically underfunded, with the result that a lot of the health infrastructure and equipment is in a state of disrepair. The health manpower in the country comprises of 19, 5896 registered doctors, general physicians, 99,228 working nurses, 6,741 Lady

Health Visitors and over 100,000 Lady Health Workers. (Finance, 2016-17). The organisational setup of the public healthcare system is depicted in Fig. 1.1 below.

**Figure: 1. 1 Organization of the public healthcare system in Pakistan**



Source: Health System Profile, Pakistan, EMRO Health Observatory, WHO, 2007

The major change came in 2011, when the national legislature decision to devolve health as provincial subject to the provinces due to constitutional amendments was implemented. The Federal Ministry of Health was abolished under the 18th Amendment on 30 June, 2011. The provinces, therefore, were given the responsibility regarding their own health matters. At the federal level, however, a new ministry, namely the Ministry of National Health Services, Regulations and Coordination, was created on 4 May 2013, which performs some of the federal functions, but on a much smaller scale. Many vertical programmes being run in the country at the federal level, including the NP, have now been devolved to the provinces after the transfer of powers. Therefore, the NP at federal level does not exist, and the provinces have their own provincial LHW programmes.

### **1.3 Status of maternal and child health**

When the NP was introduced in Pakistan, the Infant Mortality Rate (IMR) was seventy-eight per thousand live births, while the Maternal Mortality Ratio (MMR)

was 276 per 100,000 live births. Maternal and child health were unsatisfactory, and the rates even higher compared to other south Asian countries. There have been many initiatives over the decade, however, to improve the health status of vulnerable populations, i.e. women and children, in Pakistan. A chronology of initiatives is given below in Table 1.1.

**Table 1.1 Maternal and child health services in Pakistan**

<b>Era</b>	<b>Area of focus</b>
<b>1950s</b>	Introduction of MCH Centres, expansion of midwifery training and introduction of Lady Health Visitors (LHVs)
<b>1960s</b>	Increase in the number of MCH Centres and Lady Health Visitors and introduction of Rural Health Centres
<b>1970s</b>	Shift in emphasis towards training of physicians at the cost of training Lady Health Visitors, and decision to appoint doctors in all primary health care centres
<b>1980s</b>	Construction of new health facilities in rural areas; training of large numbers of traditional birth attendants in safe and clean home delivery
<b>1990s</b>	Introduction of community-based Lady Health Workers; increase in availability of female healthcare providers and increase in emphasis on safe motherhood initiatives and programmes
<b>2000s</b>	Attempts to improve healthcare delivery system, decentralize management and rehabilitate the healthcare infrastructure
<b>2010s</b>	Introduction of Community Midwives, improvement of MNCH services quality

Source: National Maternal, Newborn and Child Health Program, Ministry of Health, 2006

#### **1.4 The introduction of the NP into Pakistan**

The NP was introduced into Pakistan as a novel initiative nearly a quarter of a century ago. At that juncture, the country's PHC workforce in the districts consisted of public health managers, doctors, Lady Health Visitors (LHVs), facility-based healthcare staff and a few cadres of outreach staff, e.g. vaccinators. The infant and maternal mortality rates were unacceptably high and national targets for their reduction were not being achieved. Until that time, the main focus was on static, facility-based services, complemented by some outreach preventive services through vaccinators and LHVs.

A large gap existed in reaching women in their communities. In the public sector, no health functionaries had been deployed at the community level. The activities of the health department were mainly confined to the precincts of health facilities. There were a few community health-worker initiatives in Pakistan, though none on a national scale. These programmes were mostly being run by NGOs outside the ambit of the public sector.

In 1993, Benazir Bhutto was re-elected as prime minister of Pakistan. Mother and child health issues were high on her government's agenda. The turning point was Bhutto's state visit to Iran in her first year of office. During this trip, she visited the health house of an Iranian CHW, i.e. Behvarz, and received a briefing on the success of the Behvarz Programme in Iran. She was so impressed that, upon her return, she directed the Ministry of Health to plan a similar initiative in Pakistan. In 1994, there was thus a paradigm shift when the Prime Minister's Programme for Family Planning and Primary Health Care was launched and an innovation, the Lady Health Worker, was introduced.

The National Programme for Family Planning and Primary Health Care<sup>2</sup> (NP), which was commonly referred to as the Lady Health Workers' Programme, was included in the eighth five-year plan (Pakistan, 1993). This initiative aimed at increasing access to basic preventive healthcare services, particularly in rural areas. There are currently around 100,000 LHWs working in almost all districts of the country and reaching about 75 million people (Pakistan., 2005). The NP was an extension of the outreach health services in rural and less developed urban areas (Health., 1993).

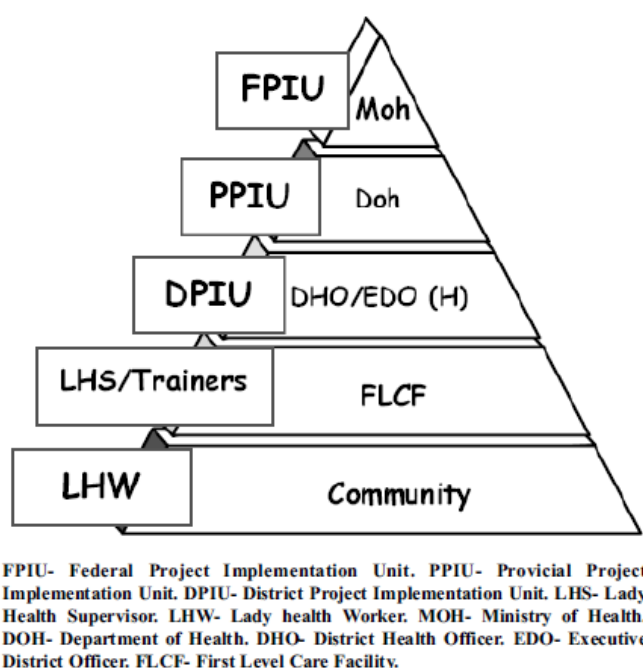
These health workers were envisaged as the linchpin for improving maternal and child healthcare services in Pakistan in rural areas and amongst the urban poor. LHWs were expected to be trained across the country in a phasic manner. Prior to being launched at the national level, a pilot was conducted in 1994, followed by a scaling-up

---

<sup>2</sup> Formerly named the Prime Minister's Programme for Family Planning and Primary Health Care, it was renamed as the National Programme for Family Planning and Primary Health Care (NP) and is commonly referred to as The Lady Health Worker Programme (LHWP). Throughout the rest of this document, it will be referred to as the National Programme, or NP.

throughout Pakistan. In the beginning, this seemed like a highly ambitious top-down initiative with very strong political commitment, especially in light of the lack of prior experience and any existing infrastructure in the public sector. The organisation of the NP prior to the devolution process is shown in Fig. 1.2 below.

**Figure: 1.2 Organisation of the NP in Pakistan**



Source: (Hafeez et al., 2011).

Launched in 1994 to mitigate the basic health problems of women and children, the NP aimed to address primary healthcare issues in the urban slums and rural areas of Pakistan. The provision of promotional, preventive and curative services in addition to family planning on the doorstep of each individual household was its main objective. This was to be accomplished through raising awareness, changing attitudes and mobilising the communities. The NP was a grassroots, community-based programme designed to bridge the gap between communities and health centres and to enhance the utilisation of available healthcare services. The LHWs deliver a range of services related to maternal and child health, including promoting childhood

immunization, growth monitoring, family planning, and improving the nutritional status of women and children. They treat minor ailments and injuries, and are trained to identify and refer more serious cases. Their family planning responsibilities include motivating women to practice family planning, providing pills and condoms, and referring them for injections, IUDs and sterilization (Health, 1996).

LHWs must have a minimum of eight years of education and be a resident of the community they serve. They undergo fifteen months of training, three months full-time followed by twelve months of in-service training. Each LHW is attached to a government health facility, from which they receive training and medical supplies. They serve a population of around one thousand individuals, or two hundred households. To achieve the objectives of the programme, LHWs are recruited and then trained and supervised according to predefined criteria. They receive an allowance and Lady Health Worker Supervisors (LHSs) are appointed to supervise their work in their communities. A trained LHW is supposed to provide all basic health services to her own community. The evaluation of LHWs and supervisors is done on monthly basis, and a final report is generated at end of the year (Health, 1996).

The Ministry of Health in Pakistan initiated the NP in 1994, with the aim of improving maternal and child health in the country through the provision of community-based PHC services (Ministry of Health, 2003). Since its inception, the NP has expanded to cover the entire country and has been scaled up in phases to bridge the gap between communities and health facilities by delivering low-cost, essential PHC services through LHWs. These LHWs are attached to one designated health facility located near their area of residence; their main task is to conduct regular household visits.

In Pakistan, the NP has been working for more than two decades. The NP has so far undergone four major evaluations. The major impetus of these evaluations has been on understanding the macro-level issues, primarily focusing on operational, management and supervisory aspects and emphasizing the processes and health outcomes (Oxford Policy Management, 2002, Oxford Policy Management, 2009,

Government of Pakistan, 2006, Government of Pakistan, 2007). These evaluations have shown that the programme is having a significant impact on a range of health outcomes and that there has been improvement in the mother and child health in areas served by LHWs. It has been suggested the LHWs are fully integrated into the national primary healthcare system (Hafeez et al., 2011). The NP in Pakistan is a rare example of a successful large-scale community programme using CHWs with minimum skills, and there is some evidence that it has also had a beneficial effect on neonatal survival (Bhutta et al., 2007).

### **1.5 Recent developments in the NP**

In Pakistan, the LHWs were introduced in 1994, and for more than a decade LHWs were known for their health-related tasks. They were also portrayed as such by the media and by health departments. They were confined to their communities however; gradually things started changing, especially in the wake of the eighteenth constitutional amendment. Here, the government decided to devolve the health sector to the provinces by June 2011. This was alarming and a great cause of concern among LHWs, as the NP was a federal initiative. The provinces were shying away from its ownership due to the huge financial implications and demanded that the federal government assure continued financial support for the NP. Amidst these fears, in June 2010, LHWs staged a protest in the form of a two-day hunger strike outside the country's parliament in Islamabad. At that juncture, the federal government agreed to accept their demands for permanent employee status (June 4, 2010, 2010). However, its indecisiveness, as well as that of the provincial governments, led to a further wave of protests. In their protest campaign; LHW leaders even threatened to boycott the upcoming polio immunization and other activities if their demands were not met.

From 2010, LHWs staged "*dharnas*" (protest sit-ins) in various cities including Islamabad, to draw attention to their plight (June 4, 2010). Consequently, a countrywide organization, the All Pakistan Lady Health Workers Association (APLHWA), was also formed to fight for their rights. Many protests held by LHWs in 2011 and early 2012 also turned violent. The police used tear gas to disperse the demonstrating LHWs in Karachi, resulting in physical injuries as well as the collapse of many workers. (February 16, 2012). Meanwhile, the Health Ministry was devolved

in 2011, and the NP was going to be transferred to the provinces. The fate of NP was in a limbo as LHWs were not regularised, despite the protests (2012b). Although promises were made to grant them permanent employee status in June 2010 and again in July 2012, these were not honoured (Wasif, April 17, 2012, 2013) (Onwuegbuzie and Leech, 2005).

On 18 April 2012, LHWs gathered in Islamabad and attempted to set themselves on fire. One person suffered severe burns despite the police intervention. (Shahid, 2012). Although promised, the demands of LHWs were again not met in 2013. Their protests continued in Karachi. (Iqtidaruddin, 2012). In Lahore, the LHWs also continued their struggle and took the matter up with higher authorities. In addition to their own efforts, the LHWs looked to the judiciary for support. The Supreme Court initially intervened to ensure that the LHWs were at least paid their salaries (2012a). The Supreme Court, furthermore, took a suo motto notice of their condition and ordered that the government apprise the court of any progress in the negotiations between the government and the LHWs (2012c).

LHWs held a rally on 22 December, 2012, outside the Parliament in Islamabad. The prime minister met with a delegation of LHWs on 3 January 2013, to discuss their demands. In the same month and year, after three years of struggle, the NP was finally regularised. Prior to this, the provincial governments had been reluctant to regularise the services of LHWs, primarily because of the huge financial costs this would entail. The federal government agreed to cover the cost of the regularisation for LHWs from 1 July 2012 to 2015, with funding beyond that date to be considered and debated by the Council of Common Interests (Junaidi, 2013). The prime minister's orders were not implemented immediately. On 7 March 2013, the Supreme Court ordered the federal and provincial governments to regularise the services of the LHWs with effect from July 2012. (2014). On 26 March 2013, Chief Justice once again took a suo motu notice of the issue and directed the government to regularise the services of the LHWs. The gravity of this issue can be gauged by a statement of the justice of Supreme Court who was heading a bench on one LHW's petition.



*“It is just like reaching for the stars to get our orders implemented in favour of the LHWs, who are always on the front line when it comes to extending community services to the people at the time of natural disasters, be it floods, polio or dengue outbreak.” (Iqbal, 2014).*

## **1.6 Aim**

The study aims to explore and describe how the experiences of the LHWs shape the process of their development as female health workers in the Pakistani health system, within a patriarchal context.

## **1.7 Objectives**

1. To explore how the LHWs’ life and work experiences influenced their development as health workers.
2. To examine the process by which LHWs constructed and defined their personhood
3. To understand how community- and workplace-based gender dynamics influenced the LHWs in the Pakistani health system

## **1.8 Organisation of the thesis**

This research study explores several key issues related to the personal and professional development of the LHWs, including their practices, process of socialisation and identity formation. The thesis is organised into nine chapters. The first chapter, Chapter 1, introduces the subject matter and highlights the primary motivation for embarking on this research. The main research gaps are also looked into, the chapter culminating into the aims and objectives of the research towards the end.

Chapter 2 explores the available literature, providing a review of studies conducted all over the world, with an emphasis of the CHWs. Although not many of the studies take up the CHW perspective, the rapid expansion of CHW programmes in the post Primary Health Care rhetoric provides a variety of researches and issues studied. An extensive literature review is followed by highlights of the gaps in research, which provide a logical basis for the current research. The conceptual framework is also presented towards the end of this chapter.

Chapter 3 delves into the methodological issues involved in this research. It provides details of the conception of the original idea of research, as well as all the steps taken

to convert this conceived idea into a reality. A reflexive account details my own previous experiences and how they have a bearing on the way research is conducted and findings interpreted. All the steps in the research process are described in detail as well as the backstage issues, such as consent, translation and transcription. The concurrent processes of data collection and analysis are explained too.

Chapter 4 to Chapter 8 are five chapters which describe and analyse the findings of the research. The fourth Chapter starts off with stories of four LHWs to give a flavour of the commonalities and differences between individual women. It then goes on to explore how lay women decided to become LHWs and the challenges they faced to enter this workforce, both in the health system and in the field. Individual characteristics and circumstantial issues which impact upon the everyday functioning of the LHW are explored in detail.

A conclusion at the end of each chapter summarises the main findings, sometimes with the help of a diagram.

Chapter 9 discusses the findings of the study in light of the available literature. Besides providing an overall discussion of the findings, it reflects on the strengths and weaknesses of the study. Highlighting the current debate of LHW as a lynchpin in all health- and community-related activities, it details the aspects of LHWs' lives by using the life course perspective. The chapter concludes by outlining the recommendations for policy, practice and future research.

Bibliography and various official documents are given as annexes at the end of the thesis.

# **Chapter II**

## **Literature Review**

### **2.1 Overview**

This review of literature focuses on key issues and themes relevant to the understanding of Community Health Workers (CHWs). It positions the CHWs within their communities, overall health system and within the context in which they serve. This review introduces the various nomenclatures of CHWs by which they are known, through to the multitude of tasks and responsibilities assigned to and practiced by them, to being labelled as “agents of change”. A substantial section of this chapter is devoted to the literature exploring the historical perspectives of PHC and CHWs including on-going debate on these issues within the health system. The CHWs’ unique juxtaposition at the intersection of the community and formal health system is also explored.

As most of the available literature visualises CHWs as appendages of the formal health system, the importance of viewing things from the CHWs’ perspective is emphasised. Therefore, this also highlights the various processes these workers undergo while also exploring their potential in the field. These processes include, but are not limited to, socialisation, work practices and development of the identity. The contextual factors play a significant role therefore, literature pertaining to these, from individual motivation to the overall health system issues in this context, is also included. The gender issues as a significant influence are also explored especially in relation to the patriarchal contexts. .

Synthesising various bodies of literature has allowed me to come up with a conceptual framework to use as scaffolding for my exploratory study. The purpose of this literature review is to make a case for exploring LHWs’ experiences and articulating their personal and professional development as a community-based cadre of female

health workers within the Pakistani health system. I conclude by highlighting the gaps in the literature, which justify undertaking this research.

## **2.2 Community Health Workers: a historical trajectory**

### **2.2.1 Evolution of Primary Health Care**

Immense changes in health systems around the world can be attributed to the changing socio-political environments. These transitions witnessed in the developing world created a diversity of health systems, especially after the 1950s. Initially, the rural areas comprising the majority of population had limited access, while formal health care services were primarily available in the cities. Gradually however, the impetus of provision of health services shifted to wider regional and national levels (Maru, 1983), as the governments become conscious of a need for alternative models of health service delivery especially in resource poor settings (Haliman and Williams, 1983). The introduction of the concept of PHC in the global health agenda was considered a game changer in this regard (Bennett, 1979, Benyoussef and Christian, 1977). A historical conference was held in 1978 at Alma Ata, where the concept of global universal health care was introduced (WHO. and UNICEF., 1978). As most of the newly independent countries accorded high priority to healthcare services, considering it a basic human right, this model was applauded. However, actual implementation of PHC required a mammoth effort due to the political and historical contexts of most developing nations (Woelk, 1994).

In response to Alma Ata Conference on PHC, and due to the inability of conventional health services to deliver basic health care, a number of countries began to experiment with the CHW concept (Mackay, 1982). Prior experiences were also in the CHWs favour. In China, bare foot doctors had emerged in the mid 1950s and evolved into a nationwide programme aimed at ensuring basic healthcare (Shi, 1993, Zhu et al., 1989, Hsiao, 1984, Sidel, 1972a). Thailand had also made use of village health volunteers and communicators beginning in the early 1950s (Kauffman and Myers, 1997, Sringernyuang et al., 1995). Successful experiences of such small-scale CHW projects (Newell, 1988) and bare foot doctors of China spurred this initiative of developing a CHW cadre (Sidel and Sidel, 1977). National governments were also

encouraged, pressured and guided by the international agencies to consider community-oriented approaches in delivering services to the poor (Heggenhougen et al., 1987, Ugalde, 1985, Werner, 1980). By the early 1970s, several countries had initiated implementing these types of health interventions at the national level (Ugalde, 1985). This issue will be discussed in detail later on this chapter.

### **2.2.2 Approaches to Primary Health Care**

It has been argued that PHC began a shift in health paradigms from a definition of health as limited to biomedical research, the provision of health services by professionals, and institutional care in hospitals and sub health units such as health centers to a broader focus that included the social determinants of health (Bhatia, 2014). Soon after the PHC was introduced as a new concept for health improvement in 1978 (Rifkin, 2018a), WHO declared “Health for All by the Year 2000,” creating a goal for national governments. Those not convinced with this approach favoured selective rather than a comprehensive measures, prioritising combatting diseases that were most prevalent and possible to control in developing countries (Walsh and Warren, 1980). The global economic crisis of 1980s also paved the way for the entry of the World Bank in health sector.

When the UN Millennium Development Goals (MDGs) were introduced in year 2000, global health policy shifted away from a comprehensive PHC approach that took into account social determinants to a vertical disease-focused agenda that reflected a selective PHC approach (Newell, 1988). On the 30th anniversary of the Alma-Ata declaration WHO once again called for reforms to achieve the PHC movement’s values of “equity, solidarity and social justice” (Van Lerberghe, 2008, p 16). Meanwhile many programs still pursued ways to significantly reduce maternal and childhood deaths through a community-based PHC approach (Perry et al., 2017).

Right at the outset it was suggested that though the vision and values of PHC were indisputable, translating policy into practice needed review (Walsh and Warren, 1980). The idea of “Selective primary health care” (SPHC) focusing on implementing policy for the diseases that had the highest prevalence and morbidity, highest risk of

mortality, and greatest possibility of control in terms of the cost and effectiveness of the intervention was proposed. Rejecting an interpretation of health as holistic and reflective of social justice and social determinants, SPHC put forward a view of health as dependent on vertical delivery of health services. It challenged the alternative “Comprehensive Primary Health Care” (CPHC) approaches to health improvements, which included community participation, intersectoral collaboration, and appropriate technology (Rifkin and Walt, 1986).

In this environment, a more concrete and focused policy was necessary. Universal health coverage (UHC), the subject of WHO’s *World Health Report: Health Systems Financing; The Path to Universal Coverage*, provided that focus (WHO, 2010c). WHO placed UHC in the context of PHC, grounded in human rights and equity. However, it clearly addressed solutions to providing a health service based on quality and access, focusing on the need for coverage and preventing catastrophic health payments. Instead of placing health improvements in terms of a critical component of development strategies, it narrowed the scope from including the social determinants of health to actions in the health sector and in roles for both professional and lay health-service providers. In 2015, universal health care became an indicator of achievement of the Sustainable Development Goals (SDG).

While WHO struggled how to pursue a holistic approach to health, the debate over SPHC versus CPHC became a consistent theme in translating PHC into practice. The programs struggled to decide whether to focus on priority diseases (the vertical approach) or on a broader set of conditions and activities (the horizontal approach) and to choose between epidemiological priorities (the most frequent serious, readily preventable or treatable conditions) and health priorities as perceived by the local population. The difference of opinion in this regard is shown in Table 2.1 below.

**Table No. 2.1 Selective versus Comprehensive approaches Primary Health Care**

<b>Approach</b>	<b>Selective PHC</b>	<b>Comprehensive PHC</b>
Values	Effectiveness, efficiency, cost-effectiveness	Equity, community participation, intersectoral collaboration
Concepts	Health as absence of disease	Health as well-being
Orientation and Accountability	Vertical, health depends on vertical management and support	Success depends on links between health and other sectors, community support and capacity building
Time Scope	Short-term, donor and program manager dependent	Long-term, population and public health dependent

Source: (Rifkin, 2018b)

The vertical-horizontal tension (Orenstein and Seib, 2016) was often reflected in the way health programs were established, particularly in the low and middle-income “developing countries.” The tensions could also be seen in donor financing to these countries (Oliveira-Cruz et al., 2003). In sub-Saharan Africa, vertical HIV/AIDS programs have integrated preventive programs for breast cancer and cervical cancer. These experiences called for a “diagonal” approach to disease control by integrating such programs into the existing health infrastructure and using people and resources to attack several problems at the same time (Ooms et al., 2008). The call for diagonal approaches received attention in the health literature as an argument to find ways of integrating the CPHC and SPHC approaches.

The tension between SPHC and CPHC continues to play a critical role in health planning. Although the vertical and horizontal approaches are often presented as mutually exclusive, in reality, many programs are a combination of both (Msuya, 2004). In an attempt to clarify the relationship of PHC to primary care, the Commission on the Social Determinants of Health included this statement in its 2008 report: The Alma Ata declaration promoted PHC as its central means toward good and fair global health not simply health services at the primary care level (though that was important), but rather a health system model that acted also on the underlying social, economic and political causes of poor health (Marmot et al., 2008). In a recent

development the PHC has been rejuvenated on its 40<sup>th</sup> anniversary in 2018 (Rifkin, 2018a).

### **2.2.3 Perspectives on CHWs based Community Oriented Programmes**

The bare foot doctors of China are generally considered precursors of CHW initiatives globally (Sidel, 1972b). Often referred to as the cornerstones of PHC (Bender and Pitkin, 1987), these health workers were expected to be agents of change in their respective communities (Colvin and Swartz, 2015, Rifkin, 2008). However, it was not long before the debate ensued regarding their position as lackies or liberators (Werner, 1981a). While the CHWs provided basic health services to the rural and disadvantaged population in many countries, they were also thought to empower the communities through bringing about a change in social conditions. The emerging evidence was also suggestive that CHWs had potential as individuals, however lacked the needed support from the formal health system (Werner, 1978, Stark, 1985, Frankel and Doggett, 1992, Standing and Chowdhury, 2008b). In view of lessons learnt from past experience, new roles of community based health agents in the pluralistic environment were being proposed (Werner, 1978, Stark, 1985, Frankel and Doggett, 1992, Standing and Chowdhury, 2008b).

Over time, most CHW initiatives were beset with problems, as programmes faltered and faced major difficulties. A review of six large scale CHWs programs concluded that their objectives had not been achieved due to lack of necessary support (Berman et al., 1987, Walt, 1988, Walt et al., 1990). It was argued that CHW programmes did not fail because of the CHWs, but due to the lack of facilitation they received (Berman et al., 1987, Walt, 1988, Walt et al., 1990). In studies conducted in diverse countries such as Botswana, Colombia and Sri Lanka it was observed the CHWs had become "just another pair of hands" (Berman et al., 1987, Walt, 1988, Walt et al., 1990).

The financial crunch in the 1980s and the accompanying structural adjustments strained the resources required for maintaining the CHW programmes, affecting them



adversely (Standing and Chowdhury, 2008b). When scaled up, most of these programmes fell short in terms of finances and support (Berman et al., 1987), therefore, many governments curtailed or ceased their CHW programmes by the late 1980s (Rifkin, 2008). Even though interest in this cadre faded gradually, in Bangladesh, Brazil (Rice-Marquez et al., 1988) and Nepal, large-scale CHWs programmes not only remained on the scene, but also played an important role in improving the health of the populations in these countries (Rohde et al., 2008). The CHWs have often been referred to as the main strength or corner stone of PHC system (Benyoussef and Christian, 1977). From the outset, they were envisaged not only as healthcare providers, but also as advocates for the community, functioning as a community mouthpiece in the fight against inequities. In Werner's famous words, the health worker is a "liberator rather than lackey" (Werner, 1981b). Regardless of the various ups and downs, the CHWs have always been in the limelight in the post Alma Ata era of primary healthcare, their primary focus in most countries being on increasing access to health services.

The 1990s saw a resurgence of national-scale programmes of CHWs. The World Health Organization had identified fifty-seven countries with critical shortages of health workers, estimating that four million more health workers were needed to bridge the gap (WHO, 2010b). This brought about renewed interest in CHWs, with the expectation that these health workers would help mitigate the gap in the global human resources in health. In Pakistan, the Lady Health Workers were introduced in 1994, which now number around 100,000. Many African countries followed suit. Uganda introduced its Village Health Team Strategy in 2003, followed by Ethiopia, where Health Extension Workers (HEWs) started their training in 2004 and now exceeds 30,000 in number. India also initiated a Rural Health Mission in 2005 that involved support for more than 800,000 CHWs called Accredited Social Health Activists (ASHAs) (Bhutta et al., 2010).

Although globally, the experience of the CHW programmes has been mixed, this cadre was still considered a promising option, as reflected in a call by the global task force to train one million CHWs in Africa (Singh and Sullivan, 2011). The potential of LHWs for contributing to maternal and child health, disease control programmes

and effectiveness in community-based interventions has already been widely acknowledged (Haines et al., 2007b, Kerber et al., 2007, Sanders et al., 2005, WHO, 2010a, Bangdiwala, 2011, WHO, 2011). The presence of CHWs in communities during Ebola outbreaks, earthquakes and other emergency conditions has been a rich contribution to the overall health system (Obilade, Perry et al., 2016, Fredricks et al., 2017). Their importance in achieving universal health coverage has also been frequently advocated (Tulenko et al., 2013). With an estimated five million active globally (Perry et al., 2014), the potential role of CHWs in improving health in communities cannot be overlooked.

## **2.3 Community Health Workers**

### **2.3.1 Nomenclature and definition of a CHW**

The term CHWs is used for a diverse group of health workers, synonymously used with other terms such as lay health workers, frontline health workers and close-to-community providers. These workers have also been described according to their roles, tasks, training or responsibilities, and most names highlight their supportive function in providing healthcare and health education. The World Health Organization (WHO) and International Labour Office (ILO) define CHWs as follows,

*Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers. (WHO, 1989, page 6)*

*Community health workers provide health education, referral and follow-up, case management, basic preventive health care and home visiting services to specific communities. They provide support and assistance to individuals and families in navigating the health and social services system <sup>3</sup>(page.192)*

---

<sup>3</sup> ILO. International Standard Classification of Occupations Structure, group definitions and correspondence tables; ISCO-08, International Labour Office, Geneva. 2007.

A recent systematic review has synthesized a more holistic definition of CHW, which includes the training aspect.

*A Community health worker is a health worker who carries out promotional, preventive and/or curative health services and who is the first point of contact at community level. A CHW can be based in the community or in a basic primary facility. A CHW has at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training. (Lewin et al., 2010, Olaniran et al., 2017)*

A common characteristic shared by CHWs is their work outside of the health centres and directly with people in their homes, neighbourhoods, communities, and other nonclinical spaces where health and disease are produced (Perry et al., 2014). In many countries, they belong to the lower social, economic and educational strata of population. Reportedly, most CHWs are women (Maes et al., 2014, Bhatia, 2014), some estimate their proportion to be seventy percent (Frymus et al., 2013). In some contexts, e.g. in Ethiopia, they are all female by policy (Theobald et al., 2015).

Globally, the nomenclature of CHWs varies. Altogether thirty-six different terms have been published by which CHWs are known in different countries, and this is by no means an exhaustive list (Bhattacharyya et al., 2001; Gilroy & Winch, 2006). In Table 2.2, a few titles of CHWs used in various countries with their tasks are shown.

**Table 2.2 Titles of Community Health Workers**

<b>Title</b>	<b>Single/ Multiple tasks</b>	<b>Country</b>
Accredited Social Health Activists (ASHAs)	Multiple tasks	India
Behvarz	Multiple tasks	Iran
Community Health Workers	Multiple tasks	Various countries
Lady Health Workers	Multiple tasks	Pakistan
Shasthya shebikas'	Multiple tasks	Bangladesh

Source: (Perry et al., 2014)

There have also been attempts to categorise CHWs into groups based on their education and pre-service training (Olaniran et al., 2017) to improve understanding of their function. A three-tiered hierarchy of CHWs has been proposed.

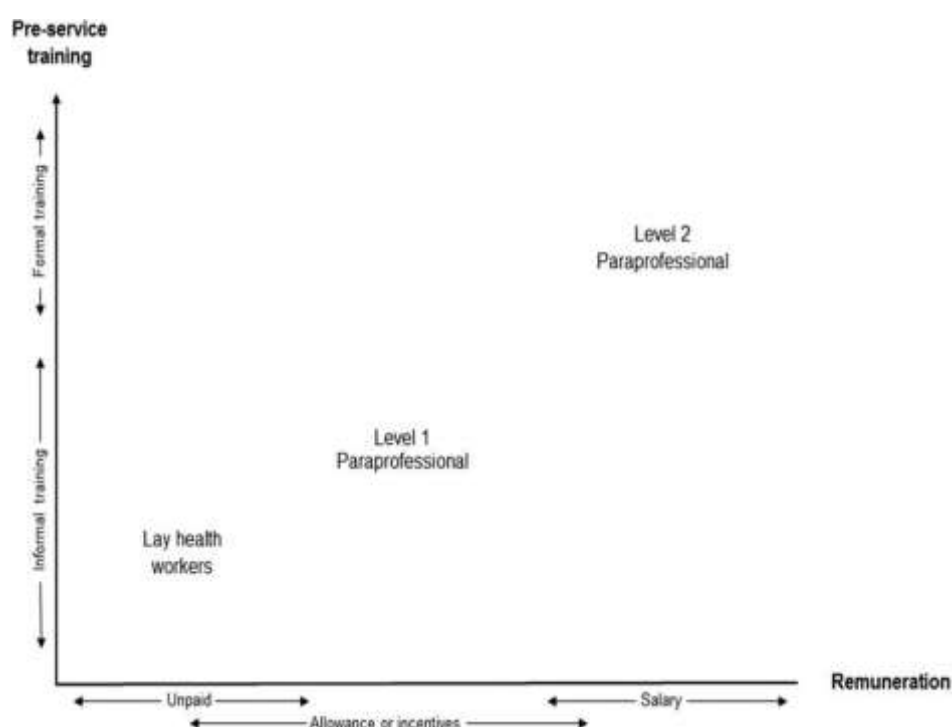
**Table 2.3 Types and characteristics of Community Health Workers**

Type	Characteristics
1. Lay health workers	Individuals with little or no formal education who undergo a few days to a few weeks of informal training
2. Level 1 paraprofessionals	Individuals with some form of secondary education and subsequent informal training
3. Level 2 paraprofessionals	Individuals with some form of secondary education and subsequent formal training lasting a few months to more than a year

Source: (Olaniran et al., 2017)

The lay health workers tend to provide basic health services as unpaid volunteers whereas level one paraprofessionals often receive an allowance and level two paraprofessionals tend to be salaried. The relationship between the training and remuneration is depicted below in Fig. 2.1. (Olaniran et al., 2017)

**Fig. 2.1 Categorising CHWs by pre-service training and remuneration**



Source: (Olaniran et al., 2017)

### **2.3.2 Assigned tasks and role of CHWs**

Although there is no perfect equation for the combination of CHW duties, recent experience has highlighted the challenges surrounding the role of these community health care providers (Ofosu-Amaah and WHO, 1983). As most national health programs operate with financial constraints and shortage of trained staff, there is a tendency to add tasks and functions continually to the duties of existing staff, and CHWs are no exception. The Alma Ata Declaration however, enumerated the following tasks expected of CHWs: “home visits, environmental sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, communicable disease control, community development activities, referrals, recordkeeping, and collection of data on vital events” (Ofosu-Amaah and WHO, 1983). This long list of responsibilities might seem unreasonable to demand from CHWs, especially the volunteer workers.

The experiences in Madagascar suggests that a CHW can manage only three or four themes at the most (Bhattacharyya et al., 2001). Apart from a consensus that no one person can manage all the activities laid out in the Alma Ata Declaration, there is little scientific evidence of the optimal number and mix of CHW functions and tasks. Programs must carefully monitor CHWs’ workloads and their effects on motivation as additional tasks are added. Some programs have found a way around this by training several people and dividing the functions among them. For example, in Nepal the village health worker does the basic preventive and curative work, while the community health leader motivates the community to participate in special campaigns (Parlato and Favin, 1982). Other programs have trained CHWs to work in a single area, such as diarrhea, malaria, or nutrition. For example, in many parts of Latin America, volunteer collaborators conduct treatment and surveillance for malaria. They make home visits to people with symptoms of malaria, complete patient reports, take blood smears, and administer doses of chloroquine (Ruebush II et al., 1994). The advantage of CHWs with a single focus is that they can be trained and monitored to

perform a manageable set of tasks. The main disadvantage is frequent training and retraining in various vertical programs, with no opportunity for integration.

### **2.3.3 Range of Services: Preventive versus curative role**

There is a wide range of different community health workers, performing an even wider range of tasks. In an extensive systematic review two kinds of CHWs, generalists and specialists were proposed (Lehmann and Sanders, 2007). Generalists performed a wide range of activities, from preventive care to first aid, covering common health and social issues in the area, such as child and maternal care, HIV/AIDS, nutrition and environmental sanitation. The community facing role of CHWs means these duties are typically carried out within households, rather than in formal medical settings. Importantly, however, generalists also act as a link between community households and the nearest health facility. They may also organise community development activities and collect data from the households (Ofosu-Amaah and WHO, 1983, Theobald et al., 2015). The roles of specialist CHWs are different, focusing primarily on specific health issues of concern to the program they are enrolled in such as maternal and child health, TB care, malaria control, or HIV/AIDS care (Lehmann and Sanders, 2007).

A key tension in the conceptualization of CHWs in the post-Alma Ata period is the range of services they are expected to provide. While developmental and educational activities are considered important, curative services are demanded by communities that do not have access to these services. Therefore, the roles and responsibilities of CHWs vary depending on facility based care and available services (Love et al., 1997). Some CHWs have only a few days of training, while others have six months or more; some receive salaries, others volunteer; some are generalists working full time, while others perform a narrowly defined set of interventions specific to one disease (Perry and Zulliger, 2012).

The tasks performed by CHWs tend to fall into four broad categories: (1) assisting individuals and communities to adopt healthy practices, (2) conducting outreach to ensure access to care, (3) providing or supporting primary and chronic care, and (4)

advocating structural changes related to community health needs (Perry et al., 2014). The proportion of tasks in each category varies by location and, as suggested in a narrative review of CHW programs, the proportion of tasks in the latter category has declined over time. Specialization may also be a response to the difficulty experienced in finding the optimal mix of CHW functions and tasks and the right balance between breadth and depth of tasks (Bhattacharyya et al., 2001).

The roles of CHWs include health promotion and disease prevention, treatment of basic medical conditions, and collection of health data. In relation to health promotion and disease prevention, CHWs are involved in activities both within the community and linked to the health facilities they are connected to. In the community, CHWs provide services to promote a healthy lifestyle and prevent disease. Acting as ‘Patient Navigators’ (Gabitova and Burke, 2014), CHWs interpret health information and provide logistical support to patients accessing healthcare within a complex healthcare system. Some CHWs have additional roles of providing treatment for basic clinical conditions and minor ailments such as malaria and diarrhea. CHWs also have a role in helping to collect and report, via existing mechanisms, information on the health of the community members (Olaniran et al., 2017). It has also been documented that if CHW do not have curative tasks and access to drugs they are not greatly valued by communities and their preventive role is undermined (Bhattacharyya et al., 2001). But when they give treatment, their attention could be totally diverted and their goals confined to the health sector as extenders of curative services (Berman et al., 1987, Walt, 1988, Walt et al., 1990).

### **2.3.4 Referral: a challenge for CHW**

Referral after providing initial management, or in case of complications is an integral part of the CHWs’ job (WHO, 2007c, WHO, 2007d, Svitone et al., 2000). A very strong, well-functioning, upstream referral system needs to be in place using which the health workers can refer complicated cases to nearby health care facility after initial management (Winch et al., 2003, Kouyaté et al., 2008, Zachariah et al., 2007). Referral is one of the four basic domains on which the CHWs are evaluated, others being primary health care delivery, family planning services and maternal and child

health care. Linking CHWs to a supportive and functioning referral facility is often vital to CHW program effectiveness (Scott et al., 2018).

A study conducted in Pakistan showed that the CHWs made 76.4% successful referrals (Afsar and Younus, 2005), however only 4% of the patients referred visited government facilities, the rest preferred private physicians and informal practitioners. A systematic review on the role of CHWs in malaria treatment found that a well functioning referral system and a reliable and consistent supply chain for getting essential medicines and equipment to the community level were instrumental for CHW performance (Paintain et al., 2014). While a functioning and bidirectional referral and feedback loop enhances CHW performance (Chanda et al., 2011), lack of the same is a known barrier to CHW effectiveness (Khan, 2011b).

CHWs however, are less concerned about receiving formal feedback than with the ability of the referral level facilities to provide the required services in a respectful and dignified manner (Prasad and Muraleedharan, 2008). The degree to which facility-based health workers respond to CHW referrals is taken as a sign of respect given to the CHW by the health system. In the long term, if community members perceive that their CHWs' referrals are not respected, they may lose trust in the CHW and not seek further services (Prasad and Muraleedharan, 2008).

## **2.4 CHWs whether agents of change or service extenders**

In developing countries, facility based approaches to health care based on western models were increasingly unable to cater to the health issues of the majority of population (Bryant, 1969, McKeown, 2014, Newell, 1975, Taylor, 1976). This was evident in failure to combat specific diseases e.g. unsuccessful global malaria eradication efforts (Cueto, 2004). This culminated in the engagement of CHWs globally in the provision of health care (Campbell and Scott, 2011). A reduction in urban bias of the health services provision was sought through this initiative, to counter reliance on doctors and health care facilities through preventive and routine curative interventions to the rural communities (Standing and Chowdhury, 2008b). Coinciding with the philosophy of decolonization and democratization forces at full



swing in many parts of the world at the time, many of the emerging economies visualized CHWs not only as providers of health care, but also liberators or indigenous agents of social change who would tackle the environmental, cultural, and political factors and thus improve health of their communities (Ballard et al., 2018, Campbell and Scott, 2011, Frankel and Doggett, 1992, Werner, 1978).

Being in line with the philosophy of CPHC accepted at Alma Ata (WHO. and UNICEF., 1978), the CHWs were viewed as a cornerstone of the paradigm shift to PHC (Lehmann et al., 2004). The PHC initially faced two challenges the first based on realism, focused on creating low cost alternatives to existing expensive urban biased health systems (Standing and Chowdhury, 2008b, Walt, 1988). The second was rooted in the social determinants of health which paved the way to ill health due to poverty and inequality. The CHWs work to influence change within communities was readily acceptable, and adopted especially in several post colonial, socialist countries in Latin America and sub-Saharan Africa (Frankel and Doggett, 1992, Bennett, 1979).

The CHWs were visualized as a cadre of agents of change, who would serve as a critical element for promoting community and individual health in addition to contributing in progressive political consciousness. These workers were expected to provide a strong and authentic connection to community needs, enabling people's participation in health practice and policy, against the top down, technocratic approaches in public health. This was based on the premise that mobilizing around health and social needs leads to political change (Eng and Young, 1992). This dual commitment of CHWs (Colvin and Swartz, 2015) fell out of favour however, as soon as selective PHC based interventions were introduced (van Ginneken et al., 2010).

The issue of limiting the role of CHWs as service extenders or allowing them to facilitate empowering communities to make decisions themselves about health and healthcare was raised right at the outset by many including David Werner in his seminal article entitled "The Village Health Worker: Lackey or Liberator?" (Werner, 1981a). CHW led empowerment of communities has been recognized as key to sustainability of various health interventions (Black et al., 2017). However, the

analysis of three large national programmes showed that while CHWs had been set up to be change agents in communities, in reality they were functioning as extensions of formal health services as auxiliaries rather than empowered agents (Gilson et al., 1989).

Many countries initiated or scaled up national CHW programs following Alma-Ata (Bhattacharyya et al., 2001), but lack of visible results led to a decline in interest among various stakeholders (Berman et al., 1987, Frankel and Doggett, 1992, Walt et al., 1990). Extrinsic factors hampering progress included the global recession of 1980s and a debt crisis in many developing countries. The World Bank structural adjustment and reforms at various levels of health sector led to reduction of public sector financing in health delivery (Standing and Chowdhury, 2008b, Walt et al., 1990) and consequently, poorly resourced CHWs programs. By the end of the 1990s most of the national CHW programs had been disbanded (Abbatt, 2005, Schneider et al., 2008)

Sometimes CHW programmes reflected social development policies in line with structural and national ideologies as in Cuba, China and Nicaragua, where the CHWs had their own significance. Other programmes were conceived as an extension of the official health system as in Iran and Venezuela and another version was focused on local rural development projects as in Guatemala and India (Newell, 1975). The extension of health care to underserved populations and to involve members of the community were common characteristics of all CHW programmes. In this sense, CHW were largely successful in assisting an unprecedented expansion of health services to previously neglected areas (Newell, 1975, Frankel and Doggett, 1992). And even being simply service extenders, without accomplishing the developmental or agent of change role, CHW were perceived as a threat to the status quo, with critics from the conservative medical establishment (Walt et al., 1990, Werner, 1978, Wood, 1990).

The emergence of HIV/AIDS pandemic and efforts to achieve health related Millennium Development Goals changed the global scenario. In light of the global health workforce shortages WHO began to promote task shifting to improve coverage and equity of care (W.H.O, 2007). The CHWs again came to limelight while redistribution of tasks to less specialized health workers was considered for extending

services to populations with limited access to health facilities (Perry and Zulliger, 2012, W.H.O, 2007, Chen et al., 2006, Hadley and Maher, 2000). Even though many countries once again initiated CHW programs, this time ethos of earlier endeavours i.e. “liberation, decolonization, democratization and self-reliance” of the 1960s were missing (Lehmann et al., 2004). For instance, the CHWs in Latin America e.g. *promotores* who had once worked at the intersection of Catholic liberation theology and the labor rights movement, were now described primarily as health extension workers, their role as organisers replaced by a largely technical function (Pérez and Martinez, 2008).

In a few instances, the role of the CHW was seen as political with less emphasis on service delivery and more on determinants of health, as health advocates who rally their communities to tackle the determinants, even in developed countries (Baker et al., 1997, Rodney et al., 1998). Contrary to the expectations, the “agents of change” model appeared only in a few countries undergoing more profound political change, or in small scale non governmental experiences; otherwise it did not go further than a rhetorical statement.

Even though the CHWs served in large numbers and were primarily rooted in their communities, the main emphasis was placed on their capacity to link the traditional and the biomedical (Akintola, 2010a). Rather than partners in community empowerment, they were considered human resources for health, and a component of the broader health system (Colvin and Swartz, 2015). This shift in thinking about CHWs and their role in public health not only reflects the evolution of public health discourse and practice over the last few decades but also captures two of the distinct ways in which CHW are categorised; either extension agent for health services in the community or agent of change working on behalf of community health and empowerment. The agent of change model still stands , though not seen in practice as extension agent model predominates (Colvin and Swartz, 2015). The differences between the two schools of thought is summarised in Table 2.3 given below.

**Table No. 2.4 CHWs as agents of change vs. extension agents**

<b>CHWs as Agents of Change</b>	<b>CHWs as Extension Agents</b>
CHWs as a way of mobilizing around broad social determinants of health and empowering individuals and communities to demand responsive and equitable health services.	CHWs as a way of improving the reach and responsiveness of health services, especially in “community” contexts outside of health facilities.
Primary focus on CHWs as an active agent of change, and a catalyst for coordinating community participation and mobilization around health, social, and political priorities.	Primary focus on CHWs as a human resource (though often volunteer in nature) within the health services who must be trained, managed, and incentivized effectively.
Often generalist in nature, with a focus on prevention, health education, and social support. Responsive to a wide range of health and social needs of individuals and families.	Often specialist in nature, with a focus on efficiently delivering targeted interventions for priority disease conditions (e.g., TB DOTS supporters, lay counselors for HIV testing, breastfeeding counseling/nutritional supplements for “at-risk” mothers).
Seen to be motivated by both moral principles/altruism but also by commitment to social and political change and empowerment.	Seen to be motivated by an altruistic impulse rooted in commitments to shared moral, religious, and community values.
Seen as rooted in local community but with a desire to catalyze organic, democratic engagement around social determinants of health	Seen as rooted in local community, acts as a cultural representative/broker between community perspectives/practice and biomedicine.

Source: (Colvin and Swartz, 2015)

At the micro-level, CHWs are in a unique position to observe and understand many of the socio-cultural and gender factors that influence health and healthcare use within households and communities (Khan, 2011b). This is due to their socio-cultural embeddedness and frequent contact with individuals in their household and community settings, as compared with relatively infrequent and brief consultations in health facilities away from their social context. However, when CHWs are required to act as agents of social change, they themselves need to feel empowered and supported through enabling environments. For example, they need to be trained in soft skills such as communication, problem-solving and assuring confidentiality at community level (Redick and Dini, 2014). The opportunity to interact with clients at household and community level gives them a better understanding about the broader context of people’s lives (Standing and Chowdhury, 2008b), however, field experiences suggest that CHWs have to negotiate gender and power relationships

within households and communities in their routine work (Theobald et al., 2016). Their own work contributes towards a process of empowerment as they are challenging social constraints and stereotypes through regular employment; being mobile within communities; and fulfilling a socially valued role (Theobald et al., 2016).

Both conceptual differentiations of CHW programmes, namely service extenders or “another pair of hands”(Walt et al., 1990), and cultural mediators between the locals and formal health system, can be used in tandem, depending on the context. While the former approach can help overcome worker shortages and reach the underserved (Haines et al., 2007a), the later can help bridge the gap in service provision and improve uptake of existing services (Bhattacharyya et al., 2001). These different approaches are all in operation to some extent. Regardless of the approach underlying the CHW programme, it is pertinent to remember that CHWs do not work in a vacuum, but are strongly influenced by the cultural, social and political environments (Palazuelos et al., 2013). A better understanding of the context and conditions in which CHWs work is essential in order to support them and help them realise their potential (Glenton et al., 2010). It has also been reported that sometimes considerable and contradictory pressures are placed on the CHWs so that they increasingly become agents of the state, frequently overburdened with directives and programmes and inadequately trained and equipped for these enhanced roles (Standing and Chowdhury, 2008b). It has been suggested that in order to be effective, the CHWs need to establish their legitimacy through means such as wider community development and continuous organisational support.

## **2.5 CHWs’ Motivation**

Reasons for becoming a CHW varied around the globe. Reportedly, there is no single impetus to join as CHWs. In South Africa a study observed complex motivations underlying volunteering in AIDS care (Akintola, 2010b, Glenton et al., 2010, Kaler and Watkins, 2001, Kironde and Klaasen, 2002, Rödlach, 2009, Swidler and Watkins, 2009). In Nepal researchers concluded it was not only the monetary incentives of

CHWs which was important, there should be alignment between expectations of various stakeholders (Akintola, 2010b, Glenton et al., 2010, Kaler and Watkins, 2001, Kironde and Klaasen, 2002, Rödlach, 2009, Swidler and Watkins, 2009). In absence of monetary incentives the attrition rates of CHWs is high therefore, it has been suggested in a South African study incentives should be given to motivate volunteers (Akintola, 2010b, Glenton et al., 2010, Kaler and Watkins, 2001, Kironde and Klaasen, 2002, Rödlach, 2009, Swidler and Watkins, 2009). Some health workers expected better job opportunities, while others wanted to alleviate the suffering of others and serve their clients (Akintola, 2010b, Glenton et al., 2010, Kaler and Watkins, 2001, Kironde and Klaasen, 2002, Rödlach, 2009, Swidler and Watkins, 2009). For many, this decision was value-based, as their desire to improve the lives of others partly emanated from their religious or family values (Maes et al., 2014).

Studies also reported that CHWs joined because they wanted to increase their knowledge and skills in order to benefit personal and family health (Ramirez-Valles, 2001). Skill improvement and self-development were expectations of joining because CHWs perceived work as a stepping stone to greater goals and an appealing income-generating activity (Zulu et al., 2014). Self-motivation, autonomy, and family support were mentioned less often as sources of recruitment motivation for CHWs. In particular, CHWs foresaw increased credibility through affiliation with health services and professionals (Walt et al., 1989).

Some individuals reported being victims of structural violence such as war or having encountered issues in the health system such as epidemics, and were thus influenced by their own experiences. The intent to improve the economic and health status of their communities was also an impetus for some CHWs. In different countries such as Pakistan, Ethiopia, and Mozambique, the reasons for joining were different. It has been argued that where an individual comes from and where he or she intends to proceed morally, socially, and economically are equally important considerations (Maes et al., 2014).

Motivation to begin working as a CHW primarily arose from individual level motivation. Indeed, social responsibility and altruism have been mentioned as a

motivating factor to join by CHWs (Gopalan et al., 2012, Rahman et al., 2010). Studies reported that CHWs were motivated to join as a way to progress community development (Mpembeni et al., 2015, Zulu et al., 2014). Some CHWs felt obliged to help solve community problems, often through health education (Khan et al., 1998a). CHWs referred to their personal experiences as motivating their work, having witnessed preventable loss that they wanted to shield others from (Zulu et al., 2014). Alongside their altruistic motivation, studies reported that CHWs perceived skill and knowledge advancements, professional development opportunities, and productive use of time as anticipated benefits of joining a CHW program (Gopalan et al., 2012, Greenspan et al., 2013).

In many contexts, CHWs are regarded as a labour resource available within health institutions, and not as partners (Maes et al., 2014). Many countries currently have a mix of voluntary and paid CHWs. It has been seen that, although altruism and intrinsic needs might have been the prime motivations behind becoming a nonpaid CHW, with the passage of time many became dissatisfied, as their volunteer job did not offer any financial incentives (Mpembeni et al., 2015). It was suggested that this might be due to the time being spent or a comparison with other community-level cadres who were being paid. In addition, the opportunity cost of this work was also a consideration. Other individual issues of LHWs, such as gender, lack of formal education and career enhancement opportunities, have been identified as support needs to be addressed with a rights and gender-based perspective for the smooth operation of large, public-sector CHW programmes (Bhatia, 2014).

A review of literature revealed that women in rural areas considered becoming a CHW as an opportunity or a chance to empower themselves socially, personally and financially (Willis-Shattuck et al., 2008). Some CHWs took up this job as it was the only option available in the rural areas, often the only paid work in the communities available that was not related with agriculture. According to health officials, in the mid-1990s it was difficult to recruit women, but a decade later, hordes were interested (Khan, 2011b). Generally in South Asia, household poverty forced women to enter the workforce, a phenomenon recognised in Pakistan as well (Khan and Khan, 2009). A recent study involving another cadre of community-based health workers, i.e.

Community Midwives, reported that the foremost reason stated for starting the job was financial, and families supported them in their decision because of household poverty. In Pakistan, unemployment or underemployment of a husband or head of the household reportedly led women to become LHWs (Khan, 2011b). Due to poverty, the men in the households are pushed to discard gender norms and to allow women to work as breadwinners, regardless of the status of the job (Mumtaz et al., 2015).

In a study conducted in Pakistan, the main reason given for joining the NP as LHW was poverty, and their paltry monthly stipend was reportedly the only source of income in those households and thus crucial for the family's survival (Khan, 2011b). This income was spent on the family, especially the needs of children. In many cases, an LHW's husband was not earning and the family was solely dependent upon her stipend. The decision to work was partly made by the LHW herself. The in-laws, in the case of married women, and fathers in the case of unmarried ones, encouraged them to apply so as to supplement the family income.

## **2.6 Context and performance**

Performance has been proposed as a complex social process in which interactions between health workers, communities and health system result in health workers' sense of achievement and recognition (Franco et al., 2002). The CHWs' personal knowledge and skills as well as their values and goals develop and evolve continuously (Mlotshwa et al., 2015, Rowe et al., 2005). However, their capacity to work and their motivation as well as performance are influenced by their environment. A systematic review comprising 140 studies from all over the world identified the health system factors which influence CHW performance including supervision, incentives, training, accountability and communication structures, logistics and supplies (Kok et al., 2014). The individual level factors included resource availability, competence and motivation. Contextual factors included sociocultural and gender norms and overall policies, especially those pertaining to health (Kok et al., 2014, Kok et al., 2015, Naimoli et al., 2014).

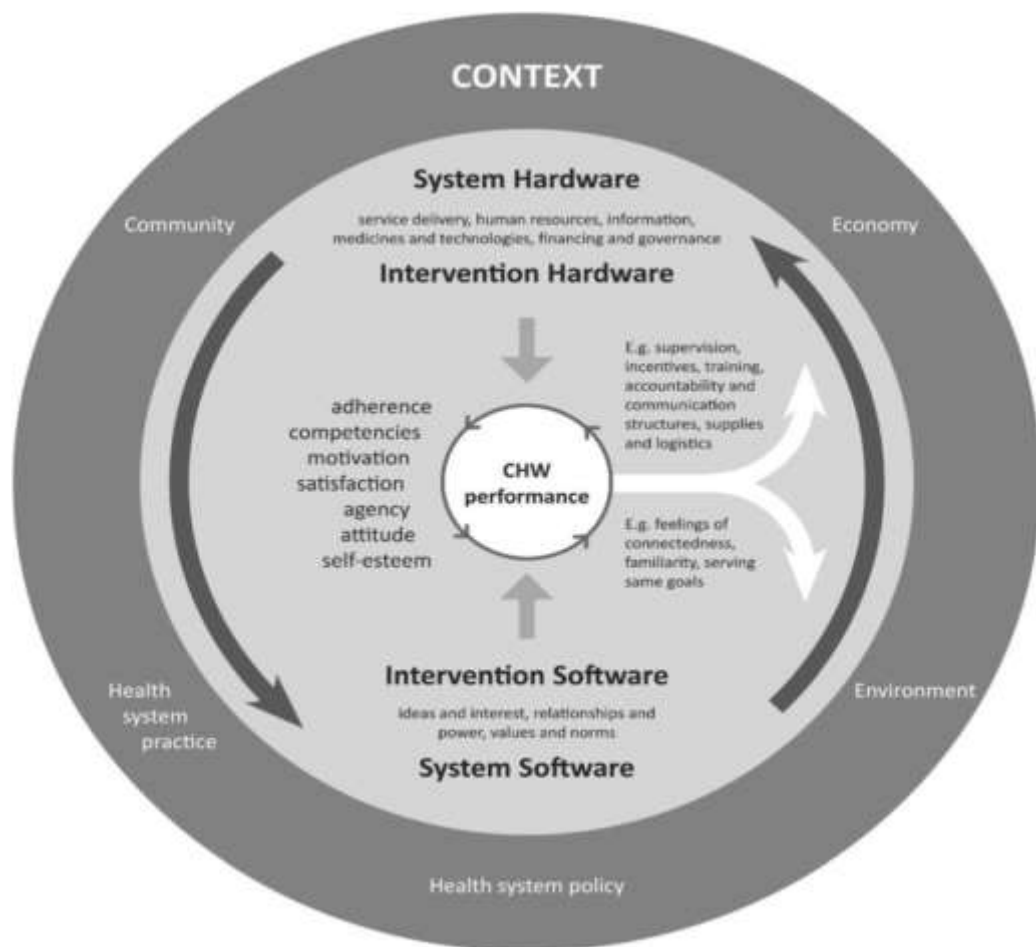


In addition, as social actors, health workers continue to stimulate trusting relationships and support interactions between individuals (Okello and Gilson, 2015, Gilson, 2003). In a study in Tanzania, good relations of the CHWs with health workers and their communities were strongly associated with their satisfaction. Logistic support, such as the availability of job aides and the capacity to provide services to the community and training, also motivated the CHWs (Mpembeni et al., 2015). Another study in Sindh, Pakistan identified the factors with the potential to improve health workers motivation (Rabbani et al., 2016). These included recognition, supportive supervision, training, availability of logistics and timely salaries. The study recommended further exploration of these factors to improve CHW performance.

### **2.6.1 The significance of contextual factors**

Numerous contextual factors have been highlighted that influence the CHWs working in their communities at multiple levels, pertaining to the individual, programme and system (Naimoli et al., 2014). Experiences with CHWs in Ethiopia, Pakistan, and Mozambique emphasise that supportive working relationships among CHWs, their communities and the institutions are vital, although not stated as an explicit goal (Maes et al., 2014). The concept that CHW performance is a transactional social process recognises the importance of relationships and power between different actors in the health system (Fig. 2.2). The following framework and its underlying hypotheses focus on CHW performance as a social process, embedded in a health system seen as a social construct (Sheikh et al., 2011). The CHWs are in the centre, while the multiple layers of influencing factors, such as the health system and the broader context, are in the outer circles. Health system-related factors are divided into “hardware” and “software” (Sheikh et al., 2011).

**Fig 2.2 Framework of CHW transactional social process**



Source: (Kok et al., 2017b)

According to this model, the performance of CHWs has been conceptualised as a transactional social process taking place within a complex that can be described as an adaptive health system. Two elements have been delineated, i.e. software and hardware. System hardware is based on the WHO's six building blocks of the health system framework (WHO, 2007b), while the software includes the ideas and interest, relationships and power, values and norms of the actors in the health system and CHW programmes (Sheikh et al., 2011). The importance of trusting relationships between all actors as a software element has been stressed. Given the intermediary position of CHWs between the community and health sector, both the hardware and

software elements act in synergy and are needed to strengthen the system, as together both can create an enabling environment. However, the intrinsic factors, such as individual personality, can still affect the performance of CHWs (Kok et al., 2017a).

Among the contextual factors that can influence CHW performance are cultural and gender norms at the community level, which have been highlighted in a recent review of literature, in addition to influences at organisational and policy level (Kok et al., 2015). Gender and power relationships have to be negotiated frequently by the CHWs within their own households and communities, but how they deal with this at the individual, community and health-system levels remains largely unexplored (Theobald et al., 2015). CHWs' positioning in their communities in terms of their gender and power dynamics might turn out to be a barrier in this work. In Pakistan's patriarchal society, LHWs are situated within the same gender systems that necessitate their appointment in the first place and therefore, they are disadvantaged by the interplay of gender, class and hierarchy (Mumtaz et al., 2003a).

### **2.6.2 Social context of female health workers - Role of Patriarchy**

The word patriarchy literally means the rule of the father or the patriarch (Bhasin, 1993). It was originally used to describe a specific type of male dominated family, in which the male head of household had absolute power over his dependent family members. Patriarchy has been construed as "the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general. It implies that men hold power in all the important institutions of society and that women are deprived of access to such power. It does not imply that women are either totally powerless or totally deprived of rights, influence and resources" (Lerner, 1986), p 239. The term however, is now also used "to refer to male domination, to the power relationships by which men dominate women, and to characterize a system whereby women are kept subordinate in a number of ways (Bhasin, 1993).

The institution of patriarchy gives power and control to males over females culturally and socially, creating different forms of women's subordination. Six structures of patriarchy have been identified comprising paid work, housework, sexuality culture,

violence and the state (Walby, 1990). Social structures which contribute towards this power and control system include household, family, state and cultural institutions which reinforce and strengthen patriarchy at all levels (Walby, 1990) (Rawat, 2014, Sultana, 2010). Patriarchy is created and sustained through social norms, values, tradition and social segregation of gender roles which is infused in the family through the lifelong process of socialisation (Bach, 1998). Patriarchy restricts women's mobility, dress, behaviour and interpersonal ties, while male dominance and power in both public and private domains of the society are ensured (Lerner, 1986).

The theories of patriarchy propose a dual system, with two distinct forms of patriarchy i.e. private and public. The private is based in households while public patriarchy is based in settings such as employment etc. The institution of family is the most influencing patriarchal structure in the private domain (Walby, 1990), also transmitting the patriarchal norms and values to the next generation (Lerner, 1986). The principle strategy of private patriarchy is segregationist and subordinating, resulting in women's subjugation within the family through gender inequalities and specified gender roles. Males are considered as heads of their families because of their breadwinning role, thus conferring the power to control the women in their families (Walby, 1990). The division of roles as home maker makes the women subordinate and dependent on male, socially, culturally and economically, making men more powerful in the family. Restricted to their homes and required to perform household tasks, the women have therefore, reduced access to resources (Duncan, 1991).

The public patriarchy on the other hand is viewed as controlling and limiting the power of females as compared to males outside home. In this form of patriarchy employment and state are most dominating social structures which influence women's standing, by supporting gender inequality and male dominance through enhancing their status, position, power and control within the society. In public patriarchy, women are allowed to take employment, but still gender inequalities persist (Atwell, 2002; Walby, 1990). Patriarchy therefore, is a dynamic phenomenon which is transformed and modified over time.

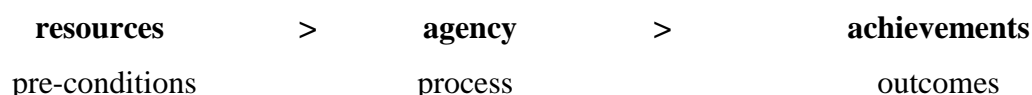
### 2.6.3 Conceptualising Gender

The concept of gender gained importance in early 1970's in feminist writings and sociological discourses. As a sociological concept, gender was introduced as an analytical category that is socially constructed to differentiate the biological difference between men and women (Oakley, 2016). The feminist argue that these differences are not biological but are social constructions of patriarchal society (Schwarzer, 1984). Gender analysis is a systematic way to identify and address key issues contributing to gender inequalities; usually involving four key components i.e. sex disaggregation, social construction, division of labour and access/control. This analysis is mostly based on the premise that development measures often impact women and men differently (Parker, 1993) .

A number of different frameworks for undertaking gender analysis have been developed to study differences between men and women in a given population. The Naila Kabeer's Social Relations Analysis (SRA) is one which follows a feminist approach (Kabeer, 1999). A holistic framework, it considers gender power relations, the gendered nature of institutions, and the interactions between different institutions. The causes of gender inequality are considered across a range of institutions at all levels i.e. micro, meso and macro levels. According to Kabeer, the institutions possess the following five aspects of social relationships: rules, resources, people, activities and power. This framework can be used to assess institutional gender policies and examination of the immediate, underlying and structural causes of gender (March et al., 1999, Kabeer, 1994).

The work of Naila Kabeer regarding gender relations in the South Asian context is considered very important. She argues that choices open to women are often limited compared to men of the same community as a consequence of gender inequality (Kabeer, 1994, Kabeer, 2005). She is of the view that in some contexts women also internalise their lesser status in society and may seem unalterable to actors in a particular social setting. Kabeer alludes to Bourdieu's idea of doxa i.e. aspects of tradition and culture which are so taken for granted that they have become naturalized (Kabeer, 1999). Therefore, available choices to the women also have the potential to counter or

reproduce social inequalities in a given society. These life choices however, influence and bring about transformatory changes in women. The increase in people's ability to make strategic life choices in a context where this ability was previously denied to them is a step towards empowerment. The ability to exercise strategic life choices can be thought of in terms of following three dimensions during the process of social change (Kabeer, 1999): The concept of resources, agency and achievement have also been used to explain the multidimensional concept of empowerment by Kabeer (Kabeer, 2005, Kabeer, 1999).



In the above process role of power is equated to the ability to make choices, while empowerment can be considered processes by which those who have been denied the ability to make choices, acquire such ability. The concept of agency relates to the processes by which choices are made and put into effect. This can be considered as the ability to define one's goals and act upon them. Agency is viewed as more than observable action, encompassing the meaning, motivation and purpose that individuals bring to their activity, or what feminists have called "the power within". Therefore, agency is considered central to the concept of empowerment.

Agency can take a variety of other forms than decision-making. It can take the form of bargaining and negotiation and other processes of reflection and analysis, exercised by an individual or groups (Kabeer, 1999). The agency is considered a process by which strategic choices are made and put into effect. Therefore, it is considered as central to the concept of empowerment as its importance is not confined to exercising choice, but also challenging the power relations. It is therefore, a wider concept not confined to decision making. The meaning, motivation, and purpose that individuals bring to their actions is also considered as their sense of agency (Kabeer, 1999).

In Kabeer's view resources are the medium through which agency is exercised. The resources are unequally distributed through the various institutions and relationships

in a society. In institutions, certain actors have a privileged position over others concerning how rules, norms, and conventions are interpreted, as well as how they are put into effect (Kabeer, 1999, Kabeer, 2005). Heads of households, for example, have decision-making authority by virtue of their position. While resources are the medium through which agency is exercised; and achievements refer to the outcomes of agency (Kabeer, 2005). The term achievements refers to the extent to which this potential is realised or fails to be realised; that is, to the outcomes of people's efforts. It depends on the agency exercised and its consequences. The resources and agency together make up people's capabilities, allowing them to live the lives they want (Sen, 1987).

These three dimensions constitute the pathways through which processes of empowerment can occur. The evidence shows that access to paid work can increase women's agency in strategic ways. Studies of the impact of microcredit in societies where women have traditionally been excluded from the cash economy have found that women's access to credit led to a number of positive changes in women's own perceptions of themselves, and their role in household decision making.

In health sector, there has been interest in the women autonomy in many developing countries. It has been observed that women have limited autonomy in accessing health care (Bloom et al., 2001, Mason and Smith, 2000, Sathar and Kazi, 2000). The concept of autonomy has been a matter of debate being at times used as a synonym of "empowerment". These terms allude to women's 'control over their lives'. The women's autonomy depends upon their decision-making authority, economic, social, emotional and physical autonomy (Jejeebhoy, 2000). The measurement of women's autonomy however is an on-going debate in the South Asian context (Agarwala and Lynch, 2006, Kishor, 2000) (Ghuman et al., 2006, Mullany et al., 2005, Sathar and Kazi, 1997).

The unaccompanied mobility of women is considered a reflection of women autonomy in South Asian context but has recently been questioned arguing that it does not explain the women's access issues completely (Mumtaz and Salway, 2009). In South Asian context it has been proposed "the goals of women's empowerment are to challenge patriarchal ideology; to transform the structures and institutions that reinforce and perpetuate gender discrimination and social inequality and to enable

poor women to gain access to, and control of, both material and informational resources" (Batliwala, 1994, p 130).

in addition to empowerment of individuals empowering the communities is now being acknowledged as an important concept underpinning CHWs' work (Maes et al., 2014). In India, the CHWs explicitly testified being empowered as a result of new gains in knowledge, freedom, and opportunity, even in the presence of managerial barriers and authoritative control (Bhatia, 2014), which highlight the need for tackling power differentials in organisations. Although it is challenging to cross professional boundaries, empowerment has been considered an essential prerequisite for bringing about a change in CHWs and their communities (Campbell et al., 2009). The empowering experience, for example, has been instrumental in the identity formation of voluntary peer group leaders, making them effective community health promoters (McCreary et al., 2013). There is some evidence that women working as CHWs have initiated a process of women's empowerment. They are pursuing a job and are mobile in their communities.

#### **2.6.4 Gender division of labour**

The gender division of labour refers to the allocation of different jobs or types of work to women and men, which has existed for a long time (Crompton, Scott, & Lyonette, 2010). The male and female domains of work were demarcated according to sex and each was a master of his or her own field of activity (Engels, 2010), a view articulated by structuralisms' theory of origin of sexual division of labour. As patriarchal societies emerged, socio-cultural socialisation led to this division of labour within household and community, generally placing greater time and energy demands on women than on men (Moser, 2012). The gender division of labor varies significantly across societies, over time and space being constantly under negotiation. These differences are most clearly illustrated by the vast differences in female labor force participation in different contexts.

The traditional division of labour most often situates women in roles based on providing emotional support and maintenance, while men are primarily responsible



for economic support and contact with the world outside the home. Despite their increased labour input into paid work, women either continue to bear the main burden of domestic work, or share it with other female members of the household. The gender inequalities and differences can be explained by differences in cultural beliefs about the appropriate role of women in a society (Fernández, 2007).

Social life in South Asia is characterized by the traditional patriarchal family system, in which men are breadwinners and authorities in the household, while females are homemakers and have lower degrees of power and autonomy (Sathar and Kazi, 1997). Rigid division of labour is also delineated by patriarchy in Pakistani society and less than 35 percent women are engaged in paid work (Isran and Isran, 2013). As a result due to the lack of access to economic resources the women's bargaining power within the household is also effected and seen as low.

#### **2.6.5 Intra household bargaining**

Many household models have presented household as a sharing, altruistic and co-operative body with a unitary utility function (Ellis, 1993). This view contradicts the possibility of intra household inequality, bargaining and conflict. However, asymmetrical power relations often result in the discrimination of women and girls in terms of the intra-household distribution of resources, including food, and access to healthcare and education. The gender of the person controlling a resource appears to have a systematic effect on patterns of resource allocation within the household (Kabeer, 1999). Therefore, unitary model of household collectivity has been widely criticised by feminists. Feminists argue that instead of household unity, there exist multiple voices, gendered interests, and an unequal distribution of resources within families and households (Wolf, 1990). In view of others household is a site of conflict as well as co-operation (Doss, 1996).

The emergence of bargaining approach within household and family is a comparatively new phenomenon in the literature of gender relationships. This approach has gained importance after the writings of renowned economist Amartya Sen, who presented a different kind of conceptualization of the relationship between

household members. Gender relations within the household can be viewed as a relation of cooperation (Sen, 1987). Kabeer argues household is a permeable and variable structure, and can be considered a site of negotiation, bargaining and conflict while considering unitary model as black box of household collectivity (Kabeer, 1994).

The study of intrahousehold decision-making concentrates firstly on intrahousehold bargaining issues and secondly this focuses on women's empowerment and agency. Many studies on women's within household bargaining power, and its relationship with household level outcomes considered factors that enhance women's position in the home. The women's contribution to household income raised her internal autonomy in contexts where traditional, religious or cultural norms otherwise limit female bargaining power (Anderson and Eswaran, 2009, Luke and Munshi, 2011). It has been observed that women who gain within household autonomy contribute in improvement of socio-economic outcomes of other members. The expenditure patterns in the household changes especially in their children's interest in terms of expenses on health and education (Doss, 1996).

#### **2.6.6 Gender norms seclusion and mobility a reflection of patriarchy**

Pakistan, like many other South Asian countries, is a strongly patriarchal society. Pakistani society has been referred to as a "classic patriarchy" where women are controlled by linking of family honour to female virtue (Critelli, 2012). The complex set of rules which governs all gender interactions, is based on an institution called purdah<sup>4</sup>. In Urdu Purdah means "curtain" however, and it commonly refers to the practice of gender segregation and the seclusion of women and girls, including use of veil in public. The use of purdah is linked with segregation and seclusion of women as "crucial characteristics of purdah observance is the limitation of interaction between the women and men outside certain well-defined categories" (Papanek, 1982, p. 519), aiming to "creation of separate worlds of man and women" (Papanek, 1982, p 528). The institution of purdah is a visible form manifesting in seclusion, dress and

---

<sup>4</sup> A Persian word that means curtain, cover, veil, privacy, modesty and secrecy (Encyclopedia of Islam 1978).

segregation of the sexes. While another invisible, is reflected in the attitudes of society.

It has been argued “One of the most defining features of Muslim Purdah is that social intercourse between men and women is confined to kinship. In this respect, social access and interaction between men and women is possible only if they are related” (Ibrah, 1993) p.no.185. A sociocultural complex namely the purdah-izzat complex has been proposed. Purdah is an elaborate social practice that is centered on the veiling and seclusion of women, whereas izzat refers to the honor conferred upon men by virtue of their wives' and daughters' conforming to the rules of the purdah complex. These rules involve the radical separation of men and women into almost mutually exclusive arenas of social interaction. Men are associated with the public sphere and women are almost totally excluded from this social arena. They are confined largely to the household and the domestic roles associated with it. The purdah-izzat complex is at the center point of an elaborate sociocultural pattern of male domination in which women are almost totally subordinated to men (Mandelbaum, 1993).

## **2.7 Socio/cultural context Pakistan and South Asia**

The Patriarchal values are deeply embedded in Pakistani society thus defining the position of women in Pakistan. The Pakistani family hierarchy divests power and control to men in the household. The Pakistani society is patrilineal in heritage and patrilocal in residence. In fact, Pakistani society, as a whole, is built around the family and household set up. Kinship and marriage are the basic institutions of the social structure. The predominant force in social organisation of Pakistani society is patriarchy, which manifests in compromising the position of women at every level (Alavi, 1991). Pakistani women are dependent on men in every walk of life. A range of institutional practices and structures influence female subordination and dependency of women on men in the Pakistani society (Niazi, 2012).

The female mobility within the Pakistani sociocultural context is closely linked with the social code of honor. Mobility is a potential risk for women as it may lead to

undesired interactions with men and loss of honor (Papanek, 1982). Therefore, the mobility of women is closely monitored by their families. In Pakistan female mobility is controlled through permission, veiling, and escort (Sathar and Kazi, 2000). Permission to leave house is usually granted mostly for subsistence activities. Purdah is considered important for social acceptance, particularly in places dominated by unrelated men. The Burka often worn by Muslim women serves this purpose and has been alluded to a portable means of seclusion (Papanek, 1982). Having an escort is important especially when the destination is outside of the local neighbourhood. These social practices vary considerably being linked to individual, household, and broader societal preferences (Khan et al., 1998a)(Khan, 1999).

The sexual division of labour places women in reproductive roles in the private sphere and men in a productive role as breadwinners in the public. Over time, due to financial needs, there is a shift in the role of women and, thus in the forms of purdah. In urban areas, the women are more visible but the segregation of sexes in institutions still persists (Zain, 2010). The mainstream of Pakistani women belongs to the rural areas who work in the fields leading a hard life for which there is neither compensation nor gratitude. Most of these women bear the double burden of housework and outside work. If they want to change their work they have few options due to low literacy (Ferdoos and Zahra, 2016). In poor households where material benefits of patriarchy are less compared with relatively rich, potential resistance to women's work at times is mellowed down however there are huge variations in the society (Ibraz, 1993).

### **2.7.1 Social context of female healthcare workers**

The gender prescribed roles have been known to impinge on the socialisation of female health workers in their communities. These workers have to face gender-based power differentials, which lead to barriers of segregation and marginalisation in dominant gender ideologies as suggested for Pakistan and Iran (Mumtaz et al., 2003b, Javanparast et al., 2011, Khan et al., 1998b). The female cadres in a conservative society may find it easier to gain access to women and children, but they may be more disadvantaged by their gender, having less access to social and public spaces

(Standing and Chowdhury, 2008a). As an implication, “Female CHWs also struggle to be recognized as skilled workers, in addition to defending at a personal level the legitimacy of their work, as it transgresses traditional norms proscribing morality and the place of women in society” p.75 (George, 2008). Thus, gender affects the social relationships and places cadres like the LHWs in a disadvantaged position. This is truer of countries like Pakistan, where a conservative patriarchal society exists.

The beliefs, values and barriers are not confined to the women in households, but also to those working in gendered professions. Many studies have been conducted in Pakistan focusing on female health workers. Contrary to nurses, who were considered to be a low-status occupation which adversely affected the status of their families (French et al., 1994), a cadre of female health workers, Lady Health Visitors (LHVs), working in the field were of the view they enjoyed respect in their communities (Upvall et al., 2002). No explanation of this disparity has been published. In another study, “disrespect from male colleagues; lack of sensitivity to women’s gender based cultural constraints; conflict between domestic and work responsibilities” were observed. (Mumtaz et al., 2003a). This study included female health workers from various cadres, including LHWs. The perspectives regarding LHWs might have changed over the years as these concerns have not been validated by the success of the LHW Programme in Pakistan (Hafeez et al., 2011). These inconsistencies may be due to the different contexts where these studies were carried out or the positioning of the different cadres of health workers or researchers.

The embeddedness of gender in the rural communities in Pakistan is complex (Mumtaz and Salway, 2009). LHWs face the challenge of balancing their roles as members of community on the one hand and as health workers in a social system where gender is an important contextual factor, on the other. The mobility of the women in communities is based on socioeconomic differentials (Mumtaz and Salway, 2005). Together, class and gender hierarchies interact to shape women’s experiences in rural areas.

## **2.8 Health System challenges: supervision and motivation**

The performance of CHWs is shaped by transactional social processes between CHWs and their environment both at the community level and in interactions with colleagues within health service delivery (Franco et al., 2002). It depends on trusting relationships among different actors, as well as experiences regarding power and hierarchy (Kok et al., 2017b). As an essential group of health workers in low and middle income countries, contributing to improved health of rural and poor communities (Perry et al., 2014), CHWs are often constrained by the plurality of tasks assigned to them and the limited support they receive from the health sector (Glenton et al., 2013). Within available support systems, supervision is often mentioned as an important programme element to increase CHW motivation and performance (Perry et al., 2014, Bhutta et al., 2010).

### **2.8.1 Supervision**

Definitions of and approaches to implementing supervision, however, vary within the health system and across different contexts. Generally, supervision involves processes of ‘directing and supporting staff so that they may effectively perform their duties’ (Marquez and Kean, 2002). Recent emphasis on the importance of ‘supportive supervision’ (Bailey et al., 2016), described as a “process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and the resolution of problems and helping to optimize the allocation of resources” (Marquez and Kean, 2002page 12), stresses that it can be distinguished from ‘traditional’ supervision as it contains the notion of humanized support, as opposed to managerial control in the latter (Hernández et al., 2014). This supervision can provide legitimacy to CHWs in the eyes of their communities (Roberton et al., 2015), and can be tailored to the local context according to the diverse capacities and needs of communities.

Supervision is an important influence on CHWs’ performance. A comparative study of four countries demonstrated a complex interplay of factors between the multiple actors involved. i.e. CHWs, supervisors and the community (Kok et al., 2017b). Firstly, the relationships among different actors, a key factor in CHW performance,

were either trusting or reflected in feelings of (dis)connectedness, (un)familiarity, and self-fulfilment. These were often related to power and hierarchy. Secondly, supportive supervision was considered a source of support, respect, competence, honesty, fairness and recognition. Thirdly, community characteristics, such as its socioeconomic situation, participation and the role of traditional leaders, influenced relationships. Lastly, the programme context included selection, recruitment and supervisory systems. Challenges faced by the large-scale CHW programmes include lack of funding, supervision and logistical support, which lead to high attrition rates of the CHWs (Perry et al., 2014).

The role of supportive supervision has been appreciated and recognized at various levels. CHWs in Ethiopia and Kenya felt that supervision added to their credibility. Their communities also favoured the supervision of CHWs. In Malawi and Mozambique, the community members believed that supervision was an important and visible form of support from supervisors towards CHWs, and looks that good relationships between these two cadres were important for quality assurance (Kok et al., 2017b).

In Mozambique, it was observed that supervision of CHWs in their communities was irregular and focused on finding fault (Ndima et al., 2015). At the Supervisors' end, reasons included high workloads as well as administrative difficulties due to higher rank in the hierarchy. Lack of training in supervision also caused problems. In Kenya, older CHWs at times refused to accept feedback from younger supervisors. In Malawi, the CHWs wanted more frequent supervisory visits. Lack of trust between CHWs and supervisors was also an issue (Kok et al., 2017b).

Evidence suggests that CHW programmes require regular and reliable support and supervision in order to be successful (Ofosu-Amaah and WHO, 1983, Bhattacharyya et al., 2001). Many policy analysts have reiterated the fact that in most of the countries, the CHW programmes are bound to fail because they are being implemented as vertical programmes, without the essential support of corresponding structural adjustments and policy measures (Walt, 1988).

### 2.8.2 Motivation

Motivation has been defined as “an individual’s degree of willingness to exert and maintain an effort towards an organisation’s goals” (Franco et al., 2002), and is considered vital for performance (Chen et al., 2004), increases motivation and job satisfaction (Rowe et al., 2005). The sources of motivation can be internal to the health workers or they can be attributed to factors in their work and social environment. In developing countries, studies on motivation are rarely conducted and are predominantly qualitative (Greenspan et al., 2013, Lindelow and Serneels, 2006). There is a need for better understanding of what motivates individuals to become and remain CHWs, however, factors contributing to motivation of CHWs are different from other health staff due to the fact that they are often not salaried, do not have prior training on community health, and constitute the outreach workforce directly linking the community with the formal health care (Gopalan et al., 2012).

Motivators are often categorized as either intrinsic or extrinsic (Franco et al., 2002, Bhattacharyya et al., 2001, Robinson and Larsen, 1990). Intrinsic motivators exist without regard to external rewards and align with personal motives and values. These motivators include empathy, altruism, pride, and a desire for self-fulfillment. Extrinsic motivators are generated from external rewards and include money and opportunities for employment, non-monetary and non-material rewards, such as heightened social status and increased knowledge. A combination of intrinsic and extrinsic motivators has been recommended to prevent CHW attrition (Bhattacharyya et al., 2001).

Motivation of CHWs studies show that the performance of CHWs improves when they receive both financial and nonfinancial incentives (Glenton et al., 2013). Lack of motivation is a known predictor of turnover and absenteeism (Dieleman and Harnmeijer, 2006). Well performing CHWs work in ways that are responsive, fair and efficient to achieve the best health outcomes possible for their clients and communities within the constraints of the resources at their disposal (Guilbert, 2006). As CHWs are situated at the interface between the health sector and communities, not only the organizational commitment but also the commitment towards the community should be looked at when assessing motivation as a determinant of performance (Naimoli et al., 2014, Kok et al., 2017a). Community context has been reported to



influence the CHW performance and programme outcomes more than in case of any other health care worker (Strachan et al., 2015).

The motivation helps retain CHWs in different settings. (Strachan et al., 2012, Glenton et al., 2013, Kok et al., 2014),(Ndima et al., 2015). In a recent review, community monitoring, quality assurance and problem-solving were acknowledged as positive attributes (Hill et al., 2014). A lack of supervision due to a lack of resources, or poorly resourced and inadequate supervisory activities (Teklehaimanot and Teklehaimanot, 2013, Sarfraz and Hamid, 2014) created a barrier in many cases (Nsabagasani et al., 2007, Smith et al., 2014, Suri et al., 2007, Scott and Shanker, 2010)

The families have also been found to be a source of motivation (Greenspan et al., 2013). the financial incentives can increase CHW motivation by contributing to financial stability (Rahman et al., 2010), and raising the status of CHWs among formally employed health worker cadres (Hafeez et al., 2011). Financial incentives in the form of salary or stipends can motivate and lead to job satisfaction and thus reduce attrition of CHW (Mpembeni et al., 2015). Remuneration can increase credibility and community trust in CHWs. The challenge, however, remains to distribute financial incentives to CHWs in an equitable and reliable way (Strachan et al., 2012).

CHWs' motivation and the status of the healthcare system appeared to be strongly linked in a study where a lack of resources and logistic issues reduced the community's trust in the CHWs (Baker et al., 2007), and affects the provision of health services to the poor vulnerable population adversely (Gopalan et al., 2012). In another study, it was observed that ASHAs were linked with a health centre lacking both infrastructure and health staff and therefore, unable to stay open twenty-four hours a day. This affected CHWs' work outcomes as this centre was being promoted for performing deliveries (Scott and Shanker, 2010).

In India, the Accredited Social and Health Activist (ASHA) workers perceived increased status in their community, but still felt that their contribution as social

change agents was not being appreciated (Scott and Shanker, 2010). Similarly, the Behvarzes in Iran, and LHWs in Pakistan perceived that they were being neglected by the health system, resulting in high job pressure (Haq et al., 2008, Javanparast et al., 2011). The conflict between expectations of the CHWs and the response of the health system in this regard influences their trajectories.

## **2.9 CHWs' work practices**

Working in health systems where there is generally a shortage of human resources, the CHWs frequently encounter a heavy workload and changing tasks, outside their normal job description. This workload reportedly stems from unrealistic expectations from the CHWs and/or from the large number of accountable households (Suri et al., 2007) and areas to be covered (Kalyango et al., 2012). In a study in South Africa, forty-three percent of CHWs considered the large number of assigned households a barrier to their work (Suri et al., 2007). In India, female health workers felt their monthly targets were unrealistic (Iyer, 2013). In Uganda, ninety-two percent of CHWs working in a follow-up programme felt reducing the workload would improve the programme's performance (Alamo et al., 2012). LHWs in Pakistan complained that they had to carry out duties that were not included in their job descriptions, e.g. loading and unloading medicine, instead of their own duties (Afsar and Younus, 2005). Increase in community-based initiatives (Gopalan et al., 2012), and task-shifting caused confusion regarding preventive or curative services (Smith et al., 2014). CHWs in Iran considered paperwork as an impediment because this increased their workload (Smith et al., 2014, Perry et al., 2013).

CHWs also reported feeling a lack of respect and support, which hindered their motivation and performance (Glenton et al., 2013). CHW programmes need support in training, supervision, and logistic issues by the health system (Perry et al., 2014). It is suggested that CHWs can only play their important role as change agents when associated with a supportive health system (Scott and Shanker, 2010).

### **2.9.1 Changes in Community Health Workers**

A review of published and unpublished literature on CHW programmes mainly found descriptive studies focusing on functions, performance and factors influencing the success and impact of CHWs activities. The impetus in the studies reviewed has been on finding mechanisms of CHWs programmes that work (Ramirez-Valles, 1998b). The results were no different in more recent reviews of CHWs (WHO, 2010a, WHO, 2007a). Therefore, very few studies have explored CHWs' career pathways, leaving gaps in understanding CHWs' perspectives.

A few of the available studies examining this topic are reviewed in the following section. A prospective study was carried out in a Village Health Worker project in Michigan. The experiences of CHWs across individual, organisational and community levels were explored. It was observed that these workers developed identities over time as they became increasingly engaged in the community project. These workers spoke of personal and collective accomplishments, but at the same time, they juggled many competing roles. There was, however, evidence of their personal development after they joined community work (Schulz et al., 1997). This was consistent with the ecological intervention approach of the project, as it addressed different levels. Multiple methods for data collection were used, but there was no mention of the number of respondents interviewed or participation observations conducted, and only one FGD session was held. In total, fifty Village Health Workers were trained, but at the end of four years, less than half of those trained were still actively working. The high attrition rate was not explained or mentioned. The authors were part of the project and their reflexivity in the process was not been made explicit.

The CHWs taking part in a long-term female CHWs project in Mexico since the 1970s were part of case studies published in three separate peer-reviewed articles. These studies dwelled on their personal experiences. The CHWs' narratives were suggestive of changes in their lives as a result of their adopted role. The two major categories of change narratives that emerged were polarized i.e. change in the self and

little or no change. However, within these major categories, there were slight variations regarding the type of change. It was reported that adopting the role of CHW changed these women's self-concepts and views on life (Ramirez-Valles, 1999).

In the above study, it was observed CHWs reinterpreted old and new behaviours and built an identity based on group culture. It has consequently been argued that the acquisition of a new set of meanings are created and shared by the group. These changes of the self are defined by women's narratives in terms of a development of self, becoming a new and different person, and an actualisation of the self. It has been suggested that the changes CHW undergo are qualitatively significant; however, they are not radical transformations of women's sense of themselves. The narratives of change are constructed in terms of a regeneration paradigm based on how life before and after working as a CHW is described and evaluated. The act of becoming a CHW is an "epiphany" that produces this transformation. The life after transformation is change or a struggle to shape one's actions according to the new self (Ramirez-Valles, 1999). The two ethnographic methods employed in this study, i.e. in-depth semi-structured interviews and participant observation, were relevant to eliciting CHWs' perspectives. However, the researcher's interpretations are given as valid explanations of reality without involving informants in the interpretive process, which is also acknowledged by the author. This might have affected the rigour of this study, especially as the researcher had nine years of experience working with the respondents, which might have influenced his interpretations.

Another study in the same location in Mexico aimed to identify and explore the motives of women for becoming CHWs. This study was informed by feminist and social constructivist insights. Women's motives for their decision fell into four categories, i.e. getting out, serving, learning, and women's betterment. These motives were not mutually exclusive, and some women used all of them. Some women became CHWs because of personal benefit, to escape seclusion of their home or to change traditional concepts of femininity and enhance opportunities for women outside the home, while others entered this field to change women and their communities. The diverse reasons and motives for becoming a CHW were constructed in an interactional and interpretative process (Ramirez-Valles, 2001). In

this study, the author did not include deviant and negative cases, which might have better delineated the categories that were generated. The exclusion of workers with less than five years of experience resulted in the study's missing some vital information, especially which on the temporal trends of change in the CHWs. The study does not probe beyond the women's motives for joining the CHW workforce, and other key issues like negotiation of their identities, the length of time they continued in their jobs and their positioning in the health system have not been addressed.

Most of the CHWs' projects are short-term; therefore issues of socialisation and negotiation of their identities remain largely unaddressed. Taking advantage of the long-term project in Mexico, the micro-processes of women CHWs involvement in community work were studied, linking individual and organisational interpretive frames. The alignment was observed to be either bridging or transformational, based on living conditions within their communities. The contextual factors, therefore, delineated the alignment process, and it was hypothesised that restrictions on women's mobility lead to a lengthy transformation process. The collective identity of CHWs was created through interactions during the frame alignment process, whereby CHWs define a common frame or orientation for their actions as a group. The creation of a common frame and a collective identity is experienced as the product of an interactive process. Women become community health workers within broader organisational and individual contexts during the course of their work (Ramirez-Valles, 2003). The study included a document review of the NGO, and views of the organisation were sought in addition to those of the women interviewed. The CHWs participated in the interview guide development, and the author was more reflexive in this study as compared to the two studies discussed earlier. The evidence in the above literature comes mainly from CHWs working in the USA and Mexico and pertains to volunteers working with non-government organizations. In other contexts, the reasons for volunteering or working may be different. There may be more than one reason for serving as a CHW; however, financial incentives are a major concern alluded to in the grey literature.

A study in South Africa explored experiences of farm Lay Health Workers in their role as health workers. The respondents' views suggested that their work had served to open up space for them to access resources and attain dreams they may never have been able to realise before. But, on the other hand, becoming an LHW may have further entrenched them in the traditional caring roles they were ascribed to. The extra responsibility outside of the home, without taking away any of those already expected of them inside the home, made their life difficult. The authors conclude by asserting that, if women are the majority of people doing various forms of informal community care, it might impinge upon the gender inequalities that already exist in their social settings (Daniels et al., 2005). The individual perspective in the study is lacking as no individual interviews were conducted. The respondents were working with a specific disease, i.e. tuberculosis; therefore their experiences might differ from that of other CHWs working on several issues.

A qualitative study exploring the pathways of LHWs and changes in their status observed diverse trajectories in their discourses based on their individual circumstances (Khan, 2008). This unpublished study was conducted in Pakistan and consisted of life histories and focus group discussions exploring why women opted to become LHWs and how empowered they were in their households. However, the way these women were situated in the health system or their interactions within it was not explored.

The double burden of CHWs, i.e. having to work in both their community and their own home, is referred to in the above studies. This dual responsibility is a major concern. The multiple roles are challenging, described by one CHW in a study carried out in Oregon as "sitting in different chairs" (Farquhar et al., 2008). Although this study was carried out on a small sample, the findings point towards an important issue of balancing life between home and work, further augmented by the fact that in many CHW programmes, married women are preferred. CHWs mostly work in their areas of residence, which might have implications for this cadre of health workers.

## **2.10 Positioning of the LHW**

### **2.10.1 Intermediary**

CHWs act as conduits between the health system and communities. Located at the margins of the formal health system, they face challenges to be recognised as health workers within primary healthcare teams. At times, their interactions pose problems, especially the relationships with health professionals in the facilities they liaise with (Schneider et al., 2008). The interactions between the CHWs and nurses has been considered a process consisting of an initiation, mutual understanding and then uneasy cooperation (Doherty and Coetzee, 2005).

By virtue of being closer to the communities, CHWs are sometimes considered as “cultural brokers”. Familiarity with the norms of their communities places them in a unique position as an intermediary between community and health system (Maes and Kalofonos, 2013), able to move within and between both. Within their communities, they enjoy a certain status due to their work, while in the health centres, they remain marginal and insecure due to their lesser skills. In cases where their work is challenged, CHWs approach the power and authority structures in their communities, who usually support them. In the case of the health services, however, they might be questioned about their performance and manner (Oliver et al., 2015).

Pakistan has stepped up its efforts to eradicate polio in the country. One of the key players involved in achieving this objective are the LHWs. It is believed that without their support polio eradication would be difficult. It has been suggested that there should be a change in thinking. Instead of treating the LHWs as disposable labour, efforts should be made to support and engage them as active partners in improving community health (Closser and Jooma, 2013). The LHWs involved in polio eradication campaigns in Pakistan are presented as selfless and extremely moral. Although referred to as volunteers, they are paid staff with designated duties. They are portrayed to donors as inspirational models of commitment to children and described as heroes (Closser, 2015).

### **2.10.2 Bridge between community and health centres**

All close to community providers, including CHWs, act as a bridge between the health system and their communities. They are situated at the interface of these two systems and need support for engaging with communities and strengthening the health system. To meet these challenges, the need for innovative mechanisms has been identified, to support the embeddedness of the CHWs at multiple levels, as well as enabling them to deliver quality services (Theobald et al., 2016). CHWs' important role as gatekeepers or negotiators of health services is often neglected (Braun et al., 2013).

CHWs' relationship with the health sector and their communities is an intricate interplay of the various stakeholders. Sometimes, the CHWs face rigid hierarchal structures in the health system (Scott and Shanker, 2010) due to the power and accountability differentials, as the say of the communities is inadequate in terms of influencing the ownership and responsiveness of CHW programmes (Kok et al., 2017b). When health systems are seen as social institutions, the hardware, namely money, material and manpower and management issues, are important but software issues, especially norms, culture and relationships including power and being part of the health system, are equally important for health workers' performance (Sheikh et al., 2011, Sheikh et al., 2014).

In many studies, the trusting and personal relationships CHWs maintain with their clients have been termed as vital for enhancing the effectiveness of their interventions (Alamo et al., 2012, Javanparast et al., 2011). In Uganda, the gender of CHWs was an important consideration and female health workers were valued by the communities for their links to the patients (Alamo et al., 2012). In Pakistan, LHWs were considered trustworthy, and relatively more acceptable to the community than other health professionals (Afsar and Yunus, 2005). In Iran, CHWs forged strong and sustainable relationships with their community, leading to recognition and enhanced contributions as health workers (Javanparast et al., 2011).



If CHWs already exist in a health system, this paves the way for new entrants since both the health system and the communities are accustomed to their presence (de Regt, 2007). Similarly, the existence of a CHW programme has implications for the CHWs as local expectations and positioning are based upon already established models (Maupin, 2011). In these circumstances, the CHWs' socialisation may be different than their earlier counterparts.

### **2.10.3 Agents of change**

The CHWs were envisioned to act as agents of change over and above the expectation to provide health care to their communities as another pair of hands (Walt et al., 1990). Considered a means of enhancing the access of health services in a cost-effective manner, they were important workers in resource poor settings (Haines et al., 2007a, Ronaghy et al., 1976, WHO, 2007d). While improving the health of the communities (Bhattacharyya et al., 2001, Kahssay et al., 1998, Witmer et al., 1995), in addition to acting as agents of social change (Lehmann et al., 2004). As intermediaries, the CHWs were expected to bridge the gap between communities and health, and support the marginalized population (Witmer et al., 1995). As agents of social change, CHWs were supposed to involve the community and solve social problems affecting health (Witmer et al., 1995). As a vast majority are women, these CHWs could also serve as a symbol of social change and empowerment in their communities (Rifkin, 2008).

The CHWs are socio-culturally embedded in their own community settings as they spend most of their time there, with lesser time spent at health centres. Working at the interface of health system and community, these health workers were facilitated by familiarity with the community's cultural norms (Lehmann et al., 2004). Due to their strategic location, they are thought to be in a position to help bring about a change in the community while addressing the health issues. Their knowledge and understanding of the cultural milieu and contextual factors affecting health, e.g. gender, also places them in a unique position (Khan, 2011b). CHWs' positioning has been acknowledged in the literature, and in the national policies of many countries.

In India, ASHAs are considered as agents of social change, over and above their prime commitment to improving mother and child health (NHSRC, 2010), not without encountering challenges (Scott and Shanker, 2010). It has been argued that structural impediments like community preferences and poor health infrastructure have hindered these CHWs from bridging the gap between health services and community needs, thus compromising their role as agents of social change (Scott and Shanker, 2010). Working in pluralistic health systems, the socialisation process of the CHWs continues within communities and health centres, and contributes towards the on going process of their own development as health workers.

#### **2.10.4 Integration into formal health systems**

Integration into the formal health system implies clearly delineated responsibilities within the health system, fair remuneration, and in some cases, the possibility of a career path (Singh and Sullivan, 2011). Even though it has been repeatedly labelled as an enabler in various reviews (Jaskiewicz and Tulenko, 2012, Kok et al., 2014, Glenton et al., 2013), there is an ongoing debate about whether CHWs should be formally integrated in the health sector (Tulenko et al., 2013, Zulu et al., 2014). The current level of integration in most countries can be likened to a ‘mosaic’ which makes it a complex, multi-functional and dynamic. It promotes accountability towards the system, while providing a sense of credibility and legitimacy to the CHWs (Kane et al., 2010). Benefits include bringing the programmes within the agendas of the ministry of health, NGOs, and international donors which leads to strengthening and sustainability (Pallas et al., 2013). Fostering respectful collaboration and communication between CHWs and higher-level staff can be mutually beneficial, increasing CHW credibility and retention (Jaskiewicz and Tulenko, 2012, Kok et al., 2015, Zulu et al., 2014). However, putting more emphasis on placing CHWs in the civil service structure or promoting community connectedness may affect the CHWs adversely and a stepwise approach has been recommended (Zulu et al., 2014).

Another facet is integration with the community (community connectedness) (Liu et al., 2011, Macinko et al., 2007) which demonstrates better outcomes due to regular

contact, consequently leading to program outcomes addressing perceived local needs (Lehmann et al., 2004). However, the gains from both types of integration are highly dependent on the strength of the health system supporting the CHW (Johnson et al., 2013). A lack of curative skills might compromise the CHWs' standing in the community (Gilson et al., 1989), as curative care is much more in demand as compared to preventive care (Walt et al., 1990). Often the relationship between the CHWs and the community suffers due to this reason.

## **2.11 Socialisation/Professional socialisation**

A person is influenced by the social systems to which they belong, whether familial or organisational, and thus socialisation is considered a lifelong learning process which enables a person to become part of a certain group. Conceptualised as a developmental process resulting from interaction between the person and the environment (Conway, 1984), socialisation is not always harmonious as there might be a disparity between expectations and real experiences (Kiger, 1993). Furthermore, power structures and social relationships in a pluralistic health care environment are also influential factors throughout the process of socialisation (Maupin, 2011, Standing and Chowdhury, 2008a).

Socialisation has been viewed as a process around and through multiple social contexts (Cohen, 1981a). The role of interaction in professional socialisation is paramount. According to many researchers, examining socialisation from a purely structural or agency perspective does not suffice; they consequently see socialisation as a dialectical process that is interactive and nonlinear, taking place between two sets of actors, i.e. those being socialised and the agents of socialisation (Kalmus, 2006). Several social theorists adhere to this view of socialisation (Berger and Luckmann, 1991, Giddens, 1984, Tierney, 1997).

The two main aspects of socialisation are the individual and society. At the macro level, socialisation occurs through a set of institutional practices, which are predominately guided by the beliefs and values of the society and organisation to

which a particular socialising agent belongs. Secondly, socialisation occurs at the micro level, i.e. the individual process relates to the daily practices of social interaction between the individuals being socialized and the socializing agent(s) (Kalmus, 2006).

The new entrants to a profession undergo a “complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession involving the internalization of the values and norms of the group into the person’s own behaviour and self-conception” (Cohen, 1981b). Individuals socialise and adjust when they join new jobs, groups, and organisations (Ashforth et al., 2007, Fisher, 1986). Socialisation is not a unilateral process imposing conformity on the individuals, but a negotiated adaptation by which people strive to improve the fit between themselves and their work environment (Schein, 1978, Nicholson, 1984). Linked to a number of personal, situational and organisational factors (Ashforth and Saks, 1995), socialisation also enables newcomers’ understanding of their new role and refines their emerging notions of who they want to be in that role (Bandura, 1977, Weick and Westley, 1996).

There is a direction of growth in the process of occupational socialisation, with four specific phases: career choice, anticipatory socialisation, conditioning and continuous commitment. (Moore, 1969). This process of nonlinear socialisation has been studied in nurses, teachers and many other professionals. A grounded theory study, for example, explored baccalaureate nursing students’ personal views on the process of professional socialisation, observing that nurses’ socialisation may even begin before they enter nursing education (Ware, 2008b). In a meta analysis of studies on early professional socialisation and career choice in nursing, it was concluded that many previously held assumptions and expectations change after working as a nurse, leading to an individually constructed reality as a nurse due to the socialisation process (Price, 2009). Being an interactional process, the socialisation of nurses influences individuals as they internalise the values, beliefs and behaviours of the nursing culture, which contribute to the development of the nurse’s identity (Hinds and Harley, 2001).

Professional socialisation has been described as a process in which the individuals develop the needed skills and adapt and adjust to their role within an organisation (Fisher, 1985, Feldman, 1981, Mackintosh, 2006). During this process, a person gives up the societal and media stereotypes prevalent in the culture and adopts those held by the members of that profession (Cohen, 1981a). In nurses, it manifests itself as a three-stage process consisting of a stage of pre-socialisation, formal socialisation and post-socialisation, which includes the career until retirement (Toit, 1995). It has been argued that professional socialisation also involves acquiring a sense of occupational identity and an internalisation of the occupational norms typical of the fully qualified practitioner (Moore, 1970).

In the 1950s, professional socialisation emerged as an area of inquiry because of two publications. One was book by Merton et al, *The Student-Physician: Introductory Studies in the Sociology of Medical Education*. (Merton et al., 1957). This work included a series of studies on professional socialisation. The other book was *Boys in White: Student Culture in Medical School* (Becker, 2002). Although both authors shared the same terminology, they explored different parts of the larger whole (Simpson and Back, 1979). Taking a structural functionalist perspective, Merton et al defined socialisation as “the processes by which people selectively acquire the values and attitudes, the interests, skills, and knowledge; in short, the culture current in the groups of which they are, or seek to become, a member” (Merton et al., 1957, p. 287). Thus the new entrants are inducted into a “common core of relatively homogeneous professional values, norms, and role definitions” (Shuval, 1980, p. 7). In contrast, the symbolic interactionist perspective focuses on the motivation, identities, and commitment of the students themselves. Socialisation is an adaptive, interactive process, in which professional norms and values are learned as during the course of professional education (Miller, 2010).

## **2.12. Development of professional identity of health workers**

### **2.12.1 Identity**

Identity is a multidimensional concept and refers to various meanings attached to a person in the development of identity, i.e. self and others. These meanings, or self-conceptions, are based on people's social roles and group memberships, as well as on the personal character traits they display, and others attribute to them, based on their conduct (Gecas, 1982). The term professional identity is not always clearly defined in the literature and is sometimes combined with the construct of self-concept, which is defined as "one's self-identity, a schema, consisting of an organized collection of beliefs and feelings about oneself" (Baron and Byrne, 1997).

For most professions, professional identities develop through socialisation, which is considered to be a complex, lifelong process which continues to evolve (Johnson et al., 2012, Ware, 2008a). In any setting, a newcomer joins an organisation with an existing identity (Michael, 1996), and constructs a new one as a result of social and cultural practices, finding their own way of becoming a professional (Michael, 1996). It has been suggested that parts of the pre-existing identities contribute to the construction of newer identities, as a relational process. As individuals move between different communities (Michael, 1996), they negotiate their position in relation to others, resulting in the construction of identity (Blåka and Filstad, 2007).

Identity is a dynamic process, in a constant state of flux as individuals continually negotiate and renegotiate the boundaries of their sense of self. Therefore, it has been argued "perhaps instead of thinking of identity as an already accomplished fact, which the new cultural practices then represent, we should think, instead, of identity as 'a production' which is never complete, always in process" (Hall and Sakai, 1998).

Another argument asserts that "... identity is a construction, a consequence of a process of interaction between people, institutions and practices" (Sarup, 1996).

### **2.12.2 Professional identity**

Professional identity is result of a socialisation process (Hall, 1987) augmented by the "position within society", "interactions with others" and "interpretations of experiences" (Sutherland et al., 2010). Professional identity is also influenced by relational and social influences within and beyond the individual's present occupation or organisation, including social positioning (Gregg and Magilvy, 2001, Dombeck, 2003, MacIntosh, 2003). It takes time to acquire, and takes shape through significant interpersonal relationships (Skorikov and Vondracek, 2011a). For instance, in nursing, this lifelong process starts prior to one's entry into nursing education, continues during training and the completion of studies to one's becoming a member of the collective.

Training plays a key role in development of professional identity (Johnson et al., 2012), for instance nurses learn the culture of the profession which they seek to join (Serra, 2008). Although occupational choice and commitment are the core attributes of identity (Kroger and Marcia, 2011), professional identity might not always be the foremost identity, as there are many other socioeconomic factors that shape the occupational appeal (Skorikov and Vondracek, 2011a). People may choose to pursue a career or work to suit their own perception of themselves, as they "tend to view a vocation as favourable or unfavourable for them because their ideas of that occupation either do or do not fit into their concept of themselves" (Davis, 1969). The dwindling numbers of nurse recruitments as well as the high attrition rates at entry levels reflect the career's lack of a desirable image (Donaldson et al., 2010).

Professional identity is a relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people position themselves in a professional role (Schein, 1978, Ibarra, 1999). It is also referred to as career, occupational or even vocational identity (Holland et al., 1993, Skorikov and Vondracek, 2011b). A study based on grounded theory explored the identity

development process of nurses and suggested that this is not static. Experienced nurses reported they rework their professional identities in response to changes in their professional lives. This process of reworking professional identity contains three stages: assuming adequacy, realising practice and developing a reputation (MacIntosh, 2003).

Another paradigm is the development of identity in non-formal settings. It has been argued that level of participation delineates identity, and some individuals may remain on the periphery, while others become embedded in the core (Lave and Wenger, 1991a). As an essential process for fulfilling professional roles, attributes acquired during socialisation should be appropriate and acceptable to the profession (Pilhammar Andersson, 1993). With time, as participants successfully enact the practices of their profession, they are identified as members of the respective profession (Wenger, 1998).

Professional identity is a form of social identity. It emerges through the social interaction between and among individuals in a professional setting. Social identity relates to the ways people compare and differentiate themselves from other professional groups (Turner, 1999). As individuals gain greater degrees of insight into professional practices and internalise the beliefs and norms of the professional group they want to join, their professional identity gradually emerges. Professional identity can be described as the attitudes, values, knowledge, beliefs and skills that are shared within a professional group. These specifically relate to the intellectual internalisation of the values, attitudes and beliefs of the professional the individual is preparing to be (Richardson, 1999).

A person's identity is portrayed and reflected in his or her narrative or story (Ricoeur, 1992). CHWs consider their relationship with their communities as important component of their own identities, even though they do not enjoy close relationships with all their clients (Maes et al., 2014). In Pakistan, the LHWs are important community-based workers, divested with many responsibilities in addition to their primary tasks. Being forerunners in repeated measles and polio immunisation campaigns (Afzal et al., 2016, Bahar et al., 2017), they are increasingly identified as



“polio workers” instead of community health workers in their communities (Fauziah et al., 2016).

### **2.13 Life course Perspective**

The life course approach studies interaction between individual lives and social change. The life course perspective provides a framework for studying phenomena at the nexus of social pathways, developmental trajectories, and social change (Elder et al., 2003). During the course of their professional life, CHWs undergo multiple transitions. These transitions encompass multiple processes including development of professional identity as a result of professional socialisation and work practices. Constructs from the life course perspective (Elder et al., 2003) can help in understanding and categorising these transitions. The three principles/constructs underlying this theory that can be used in context of my study include Trajectories, Transitions, and Turning points.

The first component of the original theory of Life Course perspective focuses on time and timing. The underlying element of temporality include patterns of stability and change, which are collectively conceptualized as trajectories (George, 2003). The second principle focuses on change, including its timing and sequence, and is encompassed by the term transitions. The third one involves abrupt and substantial change from one state to another (Cairns and Rodkin, 1998), and is labelled as turning point. This life course perspective is also pertinent as it focuses on the intersection of social context and personal biography, the former ranging from immediate social environment to wider culture while the latter concerned with personal attributes, motivations and life skills. Hence, this perspective can be a useful for unpacking the various dimensions of development of CHWs.

### **2.14 Gaps in research**

Articles about socialisation and identity formation have been published in many health-related fields, but primarily for nurses and other trained health professionals. Although there is an increasing body of literature on factors influencing CHW motivation from the perspective of the health sector, the CHWs’ perspective on their

own professional socialisation and identity has largely been ignored. Studying enabling and disabling environments that shape CHW performance could also yield evidence on specific ways to positively influence transactional social processes (Kok et al., 2017a). A lack of understanding exists about individual CHWs themselves and the contexts in which they work (Maes et al., 2014, Braun et al., 2013, Maes, 2015). In light of the importance of people-centred health systems, this lack of evidence warrants research in this area to decipher complex and adaptive health systems (Paina and Peters, 2011). The latter entails on a more holistic view of the nature of, and relationships between, all health-system stakeholders (Sheikh et al., 2014).

Most of the current probes of CHWs' work are confined to the health sector point of view. This needs to be accompanied by the voices of CHWs, which can furnish evidence about the underlying factors affecting their performance. The benefit of CHWs' unique intermediary position between communities and the health sector also need to be examined, something that ultimately could facilitate the CHWs' envisaged role in helping to achieve universal health coverage (Kok et al., 2017a). Thus, paying attention to the narratives of CHWs has been advocated as an important way of recognising the CHWs' long-term role in policy change and implementation (Maes et al., 2014).

## **2.15 Conceptual framework**

As elaborated in my constructivist epistemological position, I was interested in examining the meanings that individuals assigned to their experiences as LHWs. Whether it is through socialisation or identity, the constructivist approach acknowledges that meanings are continually being formulated. It is a perspective that permits new explanations and constructions to emerge over time (Guba and Lincoln, 1994). My study was an exploratory one based on a qualitative methodology. While I was developing it, I reviewed the literature in many disciplines, especially that in the health sector. However, the evidence on CHWs was rather scanty. During the course of this literature review and the subsequent formative part, I found that three areas were important as far as my research questions were concerned. These were the issues around the professional socialisation, practices and identity of LHWs, which are all

influenced by many overarching contextual factors, particularly that of gender. The conceptual framework was developed as a way to keep these three constructs at the forefront of my investigation.

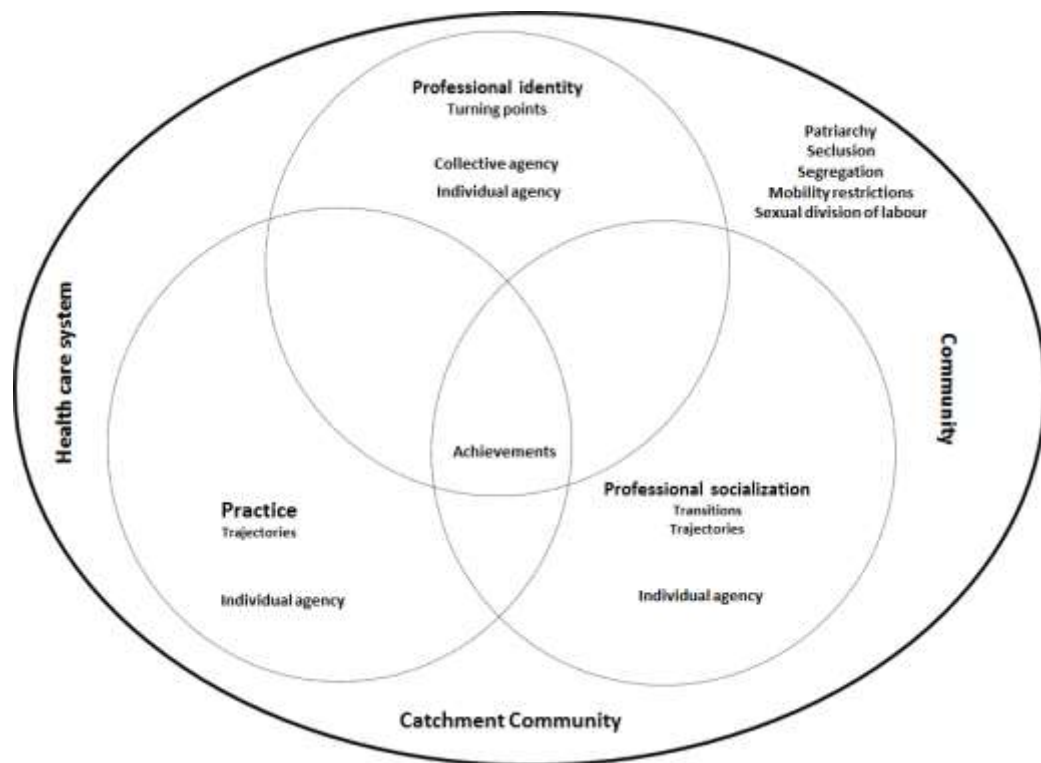
I considered existing models and frameworks, but it was challenging to find one that fit the LHWs' context. One model that did circumscribe all of these constructs was the situated learning theory, which looks at learning as a social practice. According to this theory, learning is a process that is embedded in the workplace, family and other social settings and is continually developing renewed set of relations consistent with a relational view of individuals, their actions, and the world (Lave and Wenger, 1991b). In situated learning, the development of identity is central to the career of any individual. Initially, participation was considered a process on a continuum and described as peripheral or core (Lave and Wenger, 1991b); however, the theory's proponents later added a marginal dimension, followed by the notion of legitimate forms of participation (Wenger, 1998). Some participants take on the identity of the wider community, while others choose to stay on its periphery. In the socialisation process, as participants successfully enact the practices of their profession, they become recognised as members of the profession as their participation is legitimised (Wenger, 1998).

The concept of situated learning has been developed further in the allied concept of Communities of Practice (CoP) (Brown and Duguid, 1998, Lave and Wenger, 1991b, Wenger, 1998). CoP are tightly knit groups that have been practicing long enough to constitute a cohesive community that provides a sense of belonging and commitment (Brown and Duguid, 1998, Lave and Wenger, 1991b), where meaning is negotiated and practices are developed (Lave and Wenger, 1991b, Wenger, 1998). The LHWs can therefore be considered as also CoPs, but different from the textbook definition.

The situated learning theory has been utilised in studies examining vocations and related professions as well as being adapted for use in different settings (Handley et al., 2007). The constructs of theory inform the conceptual framework of this study, as shown in Fig. 2.3. In addition I have drawn upon the concepts of life course perspective and Naila Kabeer's triad of resources, agency and achievements. Given its

exploratory and inductive nature, this study allowed for certain changes in and modifications to the conceptual framework based on collected data, on-going analysis and reflexivity. As such, this conceptual framework worked as a ‘scaffold’, with the caveat that it would be modified or even changed altogether during the course of research (Walsham, 1995).

**Figure 2.3. Conceptual framework for the study**



I chose this this conceptual framework because it seemed a pertinent tool for addressing the professional socialisation and identity of lay health workers like the LHWs. In this study, the operational definition of professional identity is “what it means to be and act as an LHW”; professional socialization refers to the “socialisation of LHWs through interaction and relationships” and practice is the “engagement of LHWs with their designated tasks”. The framework is in the shape of a Venn diagram representing three overlapping spheres of constructs: socialisation, practice and identity. As the extent and size of each sphere was yet to be explored, all were assigned equal sizes. At the formative stage of research, the relationships and

influences of the various constructs were not highlighted. This primary framework underwent many changes based on the evidence, which will be discussed in a later chapter.

# Chapter III

## Methodology

### 3.1 Introduction

This chapter outlines the methodological issues that arose during my research. The methodological considerations were of the utmost importance throughout the entire process, from conceptualising my research questions right through to writing this thesis. I begin this chapter by sharing my insights as to how I conceived this project. Who I am, I believe, has influenced each and every step of this research process; hence a large part of this chapter explains how my background and work experience helped me to shape the original concept of my research enquiry and the overall process of its exploration. Reflexivity has thus been a valuable tool for my positioning as a researcher throughout the research process, and continuous critical self-scrutiny has enriched all of my experiences.

I then explain the reasons I chose qualitative research methodology as well as the philosophical assumptions and theoretical influences that this research, including the manner in which these informed the decision-making around the research design. The conceptual framework of this study is also presented. I then discuss the ethical considerations unique to my study context, particularly how these informed my approach to recruiting research participants.

A description of the research participants is followed by an elaboration of data collection procedures including details of scheduling, influencing factors and my own personal efforts to make it a robust, informative and useful exercise. A detailed account of the way I organised my research data and analysed it, both manually as well as through use of NVivo software, is also presented. After this, I turn to the issues I encountered during data analysis and how I addressed these. Throughout this chapter, I refer to my own stance as a researcher and reflect upon the research

journey, which differentiates this chapter so that it is not simply a commentary on methodological issues.

### **3.2 Philosophical assumptions and theoretical underpinnings**

In this section, I will discuss the philosophical and theoretical underpinnings informing my research. I mainly kept three types of considerations in mind while outlining my research methodology. The first and foremost were the ontological and epistemological considerations about situating my overall research process. Second was the way these supported and led to the selection of the most appropriate methodology for examining my research questions. Last but not the least, was the choice of methods used to collect data; it was important that these aligned with the objectives of my study.

As mentioned, my first thoughts were on the ontological and epistemological issues concerning my study. Ontology refers to the nature of social world and what there is to know about it, while epistemology explains how we can learn about the social world and what the basis of our knowledge is (Ritchie et al., 2013). These key issues were important to plan, conduct and complete my research with clarity and on a sound footing.

Ontology is considered the study of being by Crotty (Crotty, 1998). The two main ontological stances in social research are realism and relativism. These two perspectives are on a continuum, but polarized between objective reality at one end and multiple realities at the other. Realism contemplates that external reality exists independent of people's beliefs about or understanding of it. This means that there is a distinction between how individuals interpret the world and how it actually is. Realism espouses the view that objects have an existence independent of the knower (Cohen et al., 2013). Relativism posits that reality is fundamentally dependent on the mind. Reality does not exist independently and depends upon the human mind and its socially constructed meanings (Ritchie et al., 2013) In terms of ontological stance, my study was closer to relativism. I was exploring trajectories of the LHWs and my inquiry could be better addressed by a relativistic approach.

The next challenge was to look for approaches appropriate to study my research questions. I wanted to examine the perspectives of the women working as health workers and give meaning to their shared experiences. I needed approaches that purported to create reality. I found interpretivism compatible with my philosophical stance. The ontological position of interpretivism is relativism, the latter being the view that reality is subjective and differs from person to person (Guba and Lincoln, 1994). Reality is individually constructed and thus there are as many realities as there are individuals. The interpretive epistemology is based on real world phenomena and states that the world does not exist independent of our knowledge (Grix, 2010). This way of thinking acknowledges that different people may construct meaning in different ways for the same phenomena (Crotty, 1998). This was very pertinent in my research as my focus was on individual LHWs and the perspectives of others around them.

The agreement of the co-constructors of research leads to truth and meanings (Pring, 2000). The role of contextual factors, including cultural and historical ones, in influencing the knowledge and construction of meaningful reality is widely acknowledged. In this regard, the interaction between humans and their world is important. It has been argued that the social world can only be understood from the standpoint of individuals who are actually participating in it (Cohen et al., 2013). Interpretive methodology is directed at understanding phenomenon from an individual's perspective, investigating the interaction between individuals as well as the historical and cultural contexts in which they live (Creswell and Creswell, 2017). This approach was consonant with my research areas of inquiry. As I was interested in exploring the perspectives of LHWs and then intended to expand the findings holistically into a meaningful reality, this stance was very pertinent.

My approach opposed the positivistic paradigm. I was framing my study on the assumption that individual constructs can be elicited and understood through the interaction between researchers and participants (Guba and Lincoln, 1994), with participants being relied on as much as possible (Creswell and Creswell, 2017). Interpretive theory is usually inductive, being generated from the data, not preceding



it (Cohen et al., 2013). My research questions were broad, and I did not envisage value-free knowledge, for as researchers, we define and choose what research is to be conducted and how to collect and interpret data (Edge and Richards, 1998). This approach was useful as it helped me gain understanding and explain the LHWs' perspective. Different methodological approaches are informed by specific philosophical or theoretical assumptions; therefore, maintaining consistency in the philosophical beginning and subsequent use of methods increases the validity of findings (Morse et al., 2001). In my case, using this approach gave me an edge because it meant that the theoretical underpinnings, methodology and methods could be aligned and interpreted in congruence. My study was also influenced and shaped by my overall constructivist approach.

During the last few decades, constructivism has emerged as a paradigm for explaining how knowledge is created (Gordon, 2009). Constructivists try to explain phenomena after studying the dynamics and social relationships between individuals (Burr, 2003). Their methodology is concerned with "interpretation, multiplicity, context, depth, and local knowledge" (Ramey and Grubb, 2009). Human meanings are therefore believed to be constructed rather than direct reflections of the actual (Raskin, 2008). This way of thinking does not consider people as creatures of determinism, but they are seen as being "socially constructed and constructing" (Sayer, 1997). The constructivist paradigm described above possessed all the characteristics that I needed to inform my research. As I was not looking for causality and my focus was on exploring and trying to give meaning to the LHWs' perspectives, my research path was delineated to justify my methodology and methods.

My research questions were exploratory, and I was not testing a hypothesis; consequently I was looking for a flexible, but still robust methodological approach. Constructivism reasons that knowledge does not exist in a form awaiting discovery (Gordon, 2009). Instead, knowledge is constructed by the humans through their interaction with the world (Morçöl, 2001). As such, there can be no objective, predetermined views and all truth is socially conditioned (Schmidt, 2001). In the opinion of many, the viewpoints expressed during research are value-laden (Gordon, 2009). It has been argued that human understanding is not based on a given

perception or observation, but on an interpretive element that determines how these elements, i.e. perceptions and observations, are understood by the researcher (Carr, 2006).

### **3.2.1 Epistemological concerns**

Another major concern for me as a researcher was to understand the epistemological issues in my study. Epistemology is defined as “the study of the nature of knowledge and justification” (Schwandt, 2001, Page 71). Epistemological issues are important considerations in the research process as these point towards the “issues about an adequate theory of knowledge or justificatory strategy” (Harding, 1987). In brief, epistemology can be considered as a justification of knowledge and the nature and forms of knowledge (Cohen et al., 2013). One of the main epistemological concerns is the quest for the best way to acquire knowledge.

*One view holds that knowledge is based on induction, a “bottom-up” process through which patterns are derived from observations of the world. In contrast, those who argue that knowledge is acquired through deduction view knowledge acquisition as a “top-down” process, whereby logically derived propositions or hypotheses are tested against observations (Ritchie et al., 2013, Page 6).*

The authors quoted above identify as positivists; their opponents comprehend knowledge based on their own perspectives and perceptions (Onwuegbuzie and Leech, 2005). If we accept the argument that knowledge is created by analysing the collected data (Carter and Little, 2007), then both types of the researchers are laying claim to truth after collecting and interpreting different types of data. It also leads many to define knowledge as a particular construction of a phenomenon (Burr, 2003). Like the diverse views in ontology, a schism exists in epistemology. The positivists and interpretivists situate themselves at different ends of the same continuum. In my study, I was exploring and as my approach was inductive rather than deductive, which in agreement with my constructivist and interpretative stance, and therefore, best suited to answer my research questions.

The epistemological considerations are important during the research process. Epistemology influences the methods of research in three ways. The influence of epistemology on the research process has been specially recognised in qualitative research. In qualitative research there is more interaction between the researchers and research participants therefore, these relationships are an important consideration. The interaction is variable participants might be considered as active contributors or as mere participants of study (Carter and Little, 2007). Epistemology also affects how data is collected, quality of methods is ensured and analysis is delineated (Angen, 2000). It plays an important role in the way the researcher conceptualizes, and communicates with, their audience. Therefore, the researcher's epistemological stance plays a key role in the research inquiry and thus affects many facets of the research process (Mantzoukas, 2004). In view of these considerations, adopting an epistemological stance is one of the first decisions to be taken when shaping methodology.

The epistemological aspects of an inquiry should be explicitly expressed while studying a phenomena, as there are some philosophical assumptions, even in the absence of explicit statements (Scott, 2005). However, using a research method as an antecedent, stand-alone activity free of any underpinning theory also occurs at times (Gee, 2005). It has been argued that it is difficult to comprehend how a researcher could collect data, for example by conducting interviews, without envisioning the nature and status of the knowledge likely to be produced about the interviewees' world. In this context, some researchers assert, it is impossible to create knowledge "without at least tacit assumptions about what knowledge is and how it is constructed" (Carter and Little, 2007, Page 1319). It should also be clear that the epistemological assumptions adopted either explicitly or implicitly will have a profound impact upon the type of data collected and the type of analysis to which it will be subjected. Within the research process, epistemology is therefore inescapable (Carter and Little, 2007). From the repertoire of methodologies, the best one for searching for answers to my study questions was the qualitative methodology.

### **3.3 Reflections on the overall research process**

This study is informed by a social constructionist approach, which means that reality is socially constructed and that different vantage points elicit different views. I explored the realities of the LHWs experience through a subjective lens, favouring an inductive approach in which the findings are derived from the data itself. Reflexivity in research acknowledges a researcher's positioning within the research process, using insights to critically examine the entire course of research.

After my degree in medicine, I acquired ten years of primary-care experience in a district in Pakistan. I pursued my postgraduate education in public health in 1994-95 overseas. I came across NP for the first time in November 1995 on my return home. In my district, the NP was launched in early 1995; I thus missed its formative phase and was not involved in the recruitment or training of LHWs. I was, however, subsequently involved in the activities of the NP, beginning in March 1996. Prior to this, I was curious about LHWs and observed them from the side lines. I spent the following five years, however, contributing to the NP in various capacities, including as a master trainer for health-centre-based training and as an LHW supervisor while in charge of a health centre. I was also overseeing their work in vaccination campaigns for polio eradication.

I was fascinated by the introduction of this new cadre of women expected to serve as a link between the formal health system and the community, and my interest continued even when my own link to the LHWs was broken when I began teaching in a public health institution in 2000. Over the last two decades, the NP, including its LHWs, has come a long way. The LHWs' performance has always been in the limelight; however, their own perspectives on their personal and professional identities are largely neglected as area of inquiry. Given my long-time interest in humanistic approaches to human resource development within organisations, I was keen to explore where the LHWs were situated after all these years. Although LHWs were proving to be a "linchpin" in the district health system based on forthcoming evidence, their own voices were still unheard. Occasionally I got the opportunity to

meet health managers working with the NP and share my concerns with them. However, they were mainly concerned with the work outputs of LHWs and their interest did not go beyond viewing LHWs as a tool for achieving public health targets.

A lot of my questions remained unanswered, and seemingly the LHW as a person was not a research priority among public-health researchers in general and the NP in particular. The impetus was mainly on programmatic evaluations of NP performance and outputs. Additionally, when I first embarked on this journey, there were not many clues forthcoming in the literature. My prime motivation here was to understand how LHWs developed their professional identities within the health system after decades of work. I wanted to know how they positioned themselves in their places of work, both in their health centre and in their community, and how they negotiated their position over time. This research is the culmination of a desire to know more about this cadre and to explore who they are now and how they reached their current standing after facing many contextual barriers. Another of my concerns was to what extent the LHWs are integrated into the district health system and whether they are now considered an asset or a liability.

### **3.4 Choosing Qualitative Research**

Qualitative research is seen mostly as a naturalistic, interpretative approach, concerned with exploring phenomena “from the interior” (Flick, 2009). One key element, namely the perspectives and accounts of research participants, exists as the starting point for this research. It has been argued the implicit diversity in qualitative research adds to its utility.

*A set of interpretive, material practices that make the world visible... These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to self ... qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them.*

*(Denzin and Lincoln, 2011, Page 3).*

Understanding the background of qualitative research guided me to use it to justify the methodology of this study. Qualitative research is often seen as a methodology opposed to the quantitative methods; however, its own characteristics and patterns have been the subject of debate. Qualitative studies are concerned with what, why and how questions, rather than with counting numbers. It is flexible, focusing more on the process, and its data collection methods include observations, interviews, and focus groups. Different qualitative researchers have used these methods with some variations (Ritchie et al., 2013). A distinct feature of qualitative research is that the hypotheses are commonly generated from an analysis of the data rather than stated at the outset (Silverman, 2015). My own study shares many common characteristics with qualitative research, from its aims and objectives to the analysis and interpretation, including a strong element of reflexivity.

I considered the theoretical tradition, school of thought, or paradigm I would use in my research. I made an effort to understand the different epistemologies, paradigms and approaches available. In particular, I wanted a flexible approach that took account of the aims and context of my study. It has been asserted that it is important to choose the appropriate method or methods for addressing specific research questions, rather than aligning oneself with a specific epistemological stance. I choose the social constructionist approach as this was suitable to my study.

Based on my research questions, I was in no doubt that qualitative research was the methodology of choice, for it not only recognises the existence of multiple realities, but also favours inductive reasoning. In addition to offering open-ended avenues for exploration, the inductive method of reasoning is flexible, providing the researcher with an opportunity to rethink and revise some aspects of the research throughout the process. The meanings and interpretations that people attach to something are valuable assets in a qualitative paradigm, informed by context, culture and personal circumstances. This methodology was the right choice to understand social phenomenon in a natural setting, giving due emphasis to participants' meanings, views and experiences. Based on the nature of the problem, my quest to explore uncharted waters and the level of explanation required, I envisaged considerable complexity. Thus, rather than predicting my results in advance, I kept an open mind

right from the outset and planned to use the data to generate explanations about the respondents' view of the world, rather than my own. Qualitative research provided me with the unique tools and analytical frames necessary to embark on my journey.

### **3.5 My reflexive positioning during the course of the study**

Reflexivity in research acknowledges a researcher's positioning in the research process, using insights to critically examine the entire process. A thorough "think through" even before I formally embarked on the process of research led me to recognise my own role here. This critical self-scrutiny enabled me to understand that no research can be value-free, and that the impact of the researcher on the research needs to be taken into account every step of the way. Reflexivity and empathic neutrality are important considerations during the course of study (Draper and Swift, 2011), the latter advocates that researchers should make the assumptions arising from their own culture, background and experience transparent. As the impact of the researcher on research settings cannot be ignored, the central role of the researcher is acknowledged in qualitative research, thus transforming subjectivity from a problem into an opportunity.

The amalgam of my formal biomedical training, education in the social sciences and exposure to public health philosophy has played an important role in my personal and professional development. I had also been fortunate enough to be able to follow the evolution of the NP, having worked in the district health system in different capacities. In my current position as a researcher familiar with the NP, I have primarily focused on the LHWs' experiences. Although it was not possible to completely separate my own beliefs and perspectives from those of the respondents, I documented my own feelings or views during my interviews and informal observations in a reflexive diary in an effort to make things transparent.

As my research involved female respondents, data collection by me, a middle-aged, male, doctor, was not without its problems. However, I was accepted as an interviewer without reservations because the topic was not sensitive. One remarkable thing was the ease with which the LHWs were able to express their feelings. I found

out that they did not need much prompting from my side, as they valued this opportunity to share their experiences. Most of my time was spent in avid listening. Seemingly, nobody had ever been interested in them as people, and that was probably another reason that lowered the power or gender differentials. Therefore, my own comfort level also improved with every additional interview.

### **3.6 Reflexivity**

I used a number of carefully planned strategies to mitigate the expected barriers during data collection. Bracketing was one such strategy, which meant suspending or holding in abeyance my own presuppositions, biases, assumptions, theories, or previous experiences, in order to see and describe the phenomenon from the respondents' perspectives (Gearing, 2004). There is no singular approach to or method for bracketing within inductive research (Tufford and Newman, 2012). By using this approach, I was able to enhance reflexivity during the course of my study, and to reduce the potential effects of my preconceptions based on my previous experiences with LHWs and the overall health system. I was keen to reflect upon how these experiences that might have shaped my interpretations as the study proceeded (Creswell and Miller, 2000).

Another strategy was maintaining a reflexive journal of my ongoing analysis of my personal experiences of and involvement in the project to keep the process more open and transparent. It also enabled me to reflect on my views, relationships and influence with respect to the participants and vice versa. I was open to the reciprocal influence of my research participants during the research process, conscious of my own and their sensitivities. I also used reflexive analysis for my field notes before and after interviews and FGDs. To enhance credibility, I used information obtained from field notes for recording observations and communication not captured by the recorder (Eisenhardt, 1989). I considered this important so that I might get a fuller, if not necessarily more concordant or truthful picture (Fade, 2003). Field notes about the overall environment in the house or office can contribute to furthering understanding, or to adding depth and breadth to the analysis of findings (Ritchie and Lewis, 2003). These notes also provide an indirect form of observational data that can complement formal methods (Berger and Luckmann, 1967).



Clarity of ideas before and after data collection facilitated the analysis stage and is documented in detail in this chapter on methodology. Regularly updating my reflexive journal facilitated my use of bracketing throughout the research process. Other strategies of positioning and building rapport with the participants to counter the hierarchical differences are explained in the section on ethical considerations, later in the chapter. A conceptual framework was developed to explore the various dimensions of my work study follows in next section.

### **3.7 Study Methodology**

#### **3.7.1 Study Design**

This was a qualitative study with a qualitative case study design (Baxter and Jack, 2008). This design allows researchers to study complex phenomenon within their context. The district was taken as a single case for this method and two methods used include Focus Group Discussions and In-depth Interviews. This approach proved to be very helpful in exploration of my phenomenon of interest, providing multiple lens to study various issues and understand these. Case study approach is based on a constructivist paradigm, which was in line with the epistemology of my study (Baxter and Jack, 2008). It also allows exploration of how and why questions without manipulating the behaviour of those involved in the study.

#### **3.7.2 Study Area**

This study was carried out in the rural outskirts of Islamabad, the national capital of Pakistan. The Islamabad Capital Territory is spread over an area of 906 square kilometres; about half of this area is classified as rural. According to the recently held census, the total population is 200, 6572 (Census, 2017). This population is almost equally divided between urban and rural areas. The rural areas included in this study come under the ambit of the health department of the Islamabad Capital Territory. The district health officer is responsible for managing the public-sector health centres in the rural areas of Islamabad.

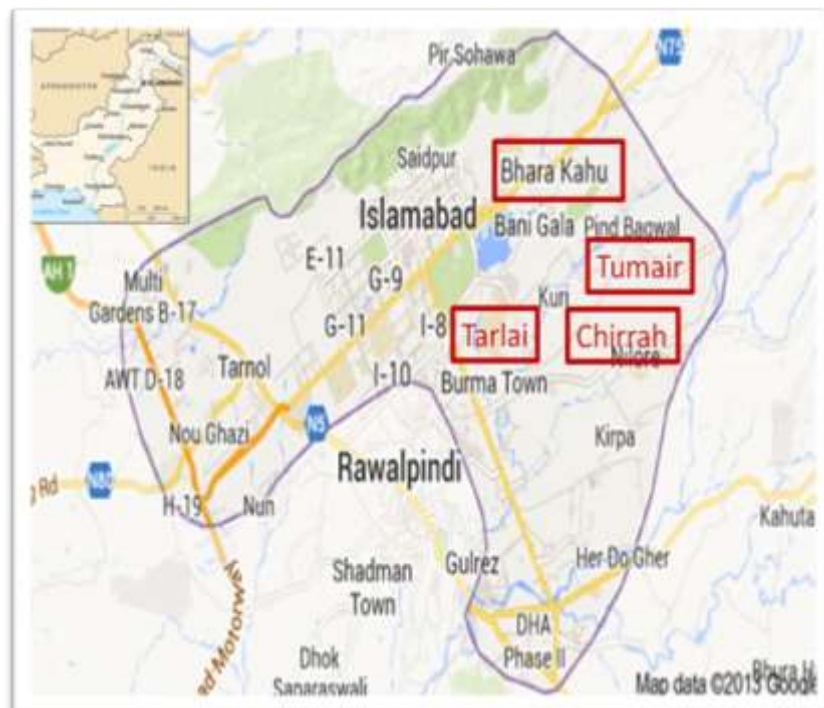
The rural area is divided into administrative units, i.e. the Union Councils, and each of these has one public-sector health centre, either a Rural Health Centre (RHC) or a Basic Health Unit (BHU). These health centres mainly offer primary healthcare services. The RHCs are better equipped in terms of human resources and infrastructure and are designated as referral hubs for the BHUs. Therefore, based on the geographic contiguity of health facilities or logistic feasibility, several BHUs are attached to each RHC for referrals and support. At present, there are eighteen health centres in the study area, including three RHCs and fifteen BHUs. All these health centres were involved with the NP, and currently 350 LHWs are working in the area.

I specifically chose this district because it was a pioneer district for the launch of the NP in 1995. The LHWs were inducted in phases and in this district all phases were represented and still working. This district enjoyed a unique position, being near a major city, rapidly emerging peri-urban settlements as well as rural areas on the outskirts. The NP in the district was performing well according to many evaluations undertaken over the years; therefore, this area seemed to be a better setting for my queries. Being close to Islamabad, this district also fared well in terms of logistics and support from the NP. The health centres, however, were not much different from remoter districts in terms of their functioning and infrastructure. Compared with many large districts, this area was a compact unit with diversity in terms of geography, communities, the healthcare system and even the LHWs. Thus, this study area provided a suitable microcosm where I could expect to find answers to my questions

The union councils in the district are diverse in terms of geography, demographic changes and development. However, they can be divided into two broad categories: rural and peri-urban, which, located nearer to the city, are rapidly transforming into urban settlements. I purposively selected four union councils, keeping in mind the visible variations in the study area. Therefore, two of the union councils represented mainly the rural outskirts, while other two were peri-urban areas. Each has a health centre serving its community, either an RHC or a BHU depending on whether the area was peri-urban or rural, respectively. LHWs were trained in each of the selected union councils in the initial cohorts of 1995-96, and many of the pioneers were still

working. The peri-urban settlements when NP was launched in 1995 were primarily rural areas. These areas were included in this study because, in addition to local women, migrant women were working as health workers in the newer settlements. To gain a better understanding of the LHWs' experiences and trajectories, both old and new LHWs were included. I specifically chose rural settings to explore how the context impinges on the LHWs' experiences. These four union councils were consequently selected because they facilitated the exploration of LHWs' different perspectives in terms of my research questions. This mix of rural and peri-urban union councils provided a good selection of LHWs, with their own unique experiences, problems and challenges.

**Fig. 3.1 Map of study area**



The context and settings of these locations are important for better understanding the narratives and perspectives of LHWs in this study. The four union councils were selected, and as each union council had a health centre, this was self-selected. A brief introduction of each of these union councils follows in order to give an idea of their locale and context.

- Union Council A is located 15 kilometres from the city centre. Two decades ago, the catchment area contained agricultural farms and brick kilns, most of which have since been converted into residential land, thus turning this area into a thriving suburb. In recent years, there has been an influx of lower- and lower-middle-class workers, employed in the nearby city. The RHC A is located in this union council. When the pioneer group of LHWs was introduced in 1995, this area was primarily rural. In the later cohorts, mostly migrants were inducted in the newer settlements, which were inhabited by recent arrivals to the area.
- Union Council B is only twelve kilometres from the city centre. It has been transformed from scattered hamlets surrounded by farmland to a densely populated suburb in the last two decades. The agricultural fields have been converted into residential areas, though not into a well-planned manner. What used to be a sleepy outskirts of the metropolis is now a bustling community. The RHC B is located in this union council. There are LHWs from the batch of 1995 to the most recent induction in 2009. This has the highest number of LHWs attached to a health centre in the district, i.e. forty.
- Union Council C is an old rural settlement and the majority of population is local. It is well connected to the city centre twenty-five kilometres away. It is comprised of hamlets surrounded by agricultural fields and interspersed with small hills. A river flows through this union council. The BHU C is located in this union council. The LHWs were first introduced in 1995 and subsequently in different phases.
- Union Council D is a sub-mountainous area twenty-eight kilometres from the city centre. Farmlands, interspersed with homes, are spread over hills. The diverse terrain also includes relatively remote areas as compared to the other areas in the study. The area boasts a river with a large dam and a

few seasonal streams. The BHU D is located in this union council. There are only twelve LHWs working here.

### **3.7.3 Study Population**

It is necessary to identify the research respondents who are able to provide the most relevant, comprehensive and richest information, by virtue of their relationship to the research question (Ritchie and Lewis, 2003). The LHWs were the primary focus of this study, while other respondents (LHS, NP managers, medical assistants, LHV, and vaccinators) were specifically selected to furnish the context. The community-based health workers, i.e. Community Midwives (CMWs), and *Dais*, i.e. traditional birth attendants, were also included in the initial plan, but later dropped as the CMWs were non-existent as a cadre, and the interaction of LHWs with other private health practitioners including *Dais* was not being encouraged by current government policy. Hence, the relationships of LHWs and private-sector health workers were explored only from the LHWs' perspectives.

### **3.7.4 Research Participants**

The four union councils described above were specifically selected to ensure the inclusion of both rural and peri-urban LHWs in the study. Once the BHUs and RHCs were selected, the sample of LHWs attached to these health centres was carefully chosen, with the intention of exploring diversity in rural and peri-urban areas and finding answers to my study questions. The LHWs were identified from the list maintained by the health centres and selected for participation in interviews and FGDs based on the considerations listed below. I selected the LHWs; the role of the health centre was minimal here except for sharing and furnishing information. With the goal of obtaining a sample of maximum variation, I kept the following key considerations in mind.

- Age (at joining the NP, current )
- Marital status (Married / unmarried / divorced / widow)
- Educational level (middle, Matric, higher education)
- Residential status (rented accommodation / self-owned house)
- Family circumstances (joint / nuclear family setup)

- Work experience (prior to the NP, working in the NP, induction phase)

Programme managers who had been involved in the NP at the national, provincial or district level were included to gain information about the context. The perspectives of these officials provided the necessary backdrop to the variety of changes occurring at programmatic level over time, which had their impact on the LHWs' functioning at health centres and in the community. These officials were individuals who had first-hand knowledge about the experiences of the LHWs and the NP and were in a position to comment on the issues being explored in this study. It is pertinent to note that not all designated seats were filled at the time of study. Furthermore, a careful selection process ensured that only those individuals participated in the study who had at least three years of experience and could contribute meaningful information towards LHWs' practices and understandings. The fact that different tiers of managerial staff existed was also taken into account, so that the basic philosophy of maximum variation sampling was not undermined. A variety of NP managers and staff, including the district coordinator, assistant district coordinator and LHS deployed in the field for supervising LHWs, were included from the four study areas. The first tier was the district health team deputed at the district health office; the views of the district health officer who heads the team as well as those of assistant district health officers, were sought. Secondly, the health personnel working in public health facilities, including medical officers, medical assistants and the Lady Health Visitors comprised respondents from the second tier. Lastly, the vaccinators and field supervisors were also included as they were working in close contact with LHWs in health centres and in communities. However, those currently working in some designated position but without any experience of the NP were excluded. A list of the various cohorts of LHWs and types of health professionals along with their numbers is given in Section 3.7.6 on sample size.

### **3.7.5 Sampling Process**

The four union councils of Islamabad Capital Territory were purposely selected as described earlier. The number of LHWs in the four union councils ranged from twelve to forty. Out of the 115 LHWs attached to the selected four health centres, twenty

seven LHWs were selected for interview, keeping in view maximum variation sampling process, while forty-six were invited to participate in the FGDs. The LHWs are functionaries of the health department; once I had the lists, I consequently approached them through the health department for inclusion in the study. I then sought, and obtained, permission from the district health officer of the Islamabad Capital Territory to this end. I commenced my study by visiting the office of the district health officer, where I briefed the district health team about the main purpose of my study and what it entailed. Following my visits to the district health office, I visited all four health centres and met the respective individuals in charge, sharing relevant information with them and apprising their staff about my study and the related logistics.

In this study, the sampling of the study sites was purposive. Qualitative researchers have been encouraged to be creative in designing sample strategies that are responsive to real-life conditions while meeting the information needs of the study; the ultimate aim is to address the problem identified for research (Coyne, 1997). The LHWs were recruited from all four health centres, using the maximum variation strategy of purposeful sampling (Etikan et al., 2016), with a view to locate and include information-rich individuals from all cohorts. This type of sampling was considered suitable due to the availability of a broad spectrum of LHWs, requiring a look at all angles for greater understanding (Etikan et al., 2016).

Due to their social skills and interactive nature, some LHWs were invited to attend more than one activity, and thus a few LHWs consequently participated both in interviews and FGDs. Similarly, some LHWs were interviewed more than once to clarify a certain point or for further elaboration of the issues raised during their initial interview (Polkinghorne, 2005)..

### **3.7.6 Sample size**

I envisaged a smaller sample size, as more than one method was being employed. I expected a point of diminishing returns with a much larger sample (Ritchie and Lewis, 2003). The sample size changed during the course of my study as I followed an iterative approach. The consideration of sample size in qualitative research is

guided by reaching data saturation, theoretical saturation, or informational redundancy (Onwuegbuzie and Leech, 2007). The distribution of the sixty-nine LHWs across the areas included in the study is given in Table 3.1.

**Table 3.1: Details of LHWs and the health facilities**

Name of Union Council	Type of Area	Type of Health Facility	Total LHWs attached to Health Facility	Included in study n (%)
1. A	Peri-urban	RHC	37	23 (62)
2. B	Peri-urban	RHC	40	13 (33)
3. C	Rural	BHU	26	21 (81)
4. D	Rural	BHU	12	12 (100)

The numbers of respondent included in this study along with their designations is given in Table 3.2.

**Table 3.2: Details of LHWs working at health facilities**

Sr. No	Designation of the respondent	Number
1	Lady Health Workers (LHW)	69
2	District Health Programme Managers (DHP Managers)	5
3	National Programme Managers (NP Managers)	5
4	Lady Health Supervisor (LHS)	5
5	Health Facility Staff	5
6	Vaccinators	3

Nine respondents were interviewed more than once, either to obtain some clarification, or when some unanticipated issue arose during the research process that needed further exploration.



### **3.8 Ethical considerations**

Ethical clearance for the research project was obtained from Ethical Review Board of the Queen Margaret University, Edinburgh, UK, after furnishing the prerequisite information such as the permission from the concerned authorities in Pakistan. The letter of Ethical Approval is given at Annex 1.

#### **3.8.1 Trust and confidentiality**

I was a medical doctor and might be considered a bit too old to be a student conducting research in a rural community setting. This was challenging, indeed, as it was not possible for me to conceal my identity as a doctor or my experience. I had to justify my student status, particularly since a few LHWs who had been part of external evaluations in the past initially took me for a consultant. Therefore, I had to give due consideration to the power imbalance between me as a researcher and the LHWs as participants. I was also slightly apprehensive that they might consider me a representative of the supervisory hierarchy, and would therefore be cautious when responding to my questions. I was wary of this concern throughout, and I put in a lot of effort into building and maintaining rapport with the respondents. I had to spend a lot of time allaying their fears. I was open to their questions and provided clarification if necessary as well as emphasising that I was only interested in hearing their stories. This generated a lot of interest on their part, and as my focus was not on evaluating their knowledge or skills, this also helped me to play down my medical background. I refrained from discussing such issues as this might have given the impression that they were being examined or have distracted them. I had some informal interaction with LHWs not included in interviews or FGDs as I believed this would allay some of the LHWs' initial fears.

These issues were not confined to LHWs. Other respondents also expressed some concerns initially. They were more worried about programmatic issues and since my focus was not on evaluating the NP but on learning about LHWs' personal experiences, this mitigated their concerns. I had expected the LHWs to be challenging and was surprised that other respondents higher up in the district hierarchy were also a bit hesitant in the beginning. Almost equal persuasive effort was needed, even where

the medical background differentials did not exist, because the curiosity about my student status persisted in many cases. Some LHWs usually spent the first few minutes justifying their performance and their contribution towards the betterment of the community. This is by no means unusual, as respondents have been known to make all kinds of effort to be seen in a positive light. The managers and many health centre staff followed suit.

Data collection from primarily female respondents (LHWs) by a male researcher in such a patriarchal setting as Pakistan was also a genuine concern. This did not pose as great a barrier to gaining access and interviewing female research participants as I had feared. The LHW are accustomed to encounters with males outside their households as part of their work and the areas of my inquiry did not infringe upon any local cultural sensitivity. Continuous reflection and rapport building also helped to mitigate this barrier, and my age and my status as a medical doctor, moreover, worked in my favour in this respect.

All the names of the respondents were changed to pseudonyms for reporting purposes. The data was kept securely, and only I had access to the complete set, with my supervisors knowing the bits I reported in write-ups. The participants were also informed through the participant information sheet about how I planned to ensure both their confidentiality and their anonymity throughout the research process.

### **3.8.2 Cultural norms and values**

I spent about two weeks on the initial reconnaissance. I visited the four union councils and their health centres and took this opportunity to address the apprehensions and anxieties of the various actors regarding my subsequent data collection. I acknowledged and identified my place and presence in the research process as a male researcher working in a patriarchal context conducting research on a female cadre of LHWs. I carefully scheduled my data collection so that ample time was spent on building rapport to reduce potential barriers, including those posed by gender.

To minimise the power differential, I wore the local dress during my field visits for interviews, instead of the western attire favoured by officials higher up in the

hierarchy. I made a conscious effort to use Urdu or the local dialect to communicate with the participants, without using English phrases, which might impeded communication. I also chose their respective health centre as a convenient and familiar venue for data collection, and refrained from making direct contact with the LHWs for recruitment purposes.

I asked the health centre staff to introduce me to the LHWs attached to their facility, preferably when the latter visited for their routine monthly meeting. I attended these monthly meetings in the four health centres, since this was the best way to meet all of the LHWs simultaneously. I informed them about my research project with an invitation to join. The LHWs showed their willingness to be interviewed in their health houses, i.e. their homes. As district policy discouraged visits by men to the houses of LHWs, I did not accept this offer. As mentioned, the fact that I was older, male, and a medical doctor clearly in a position of authority (both from a patriarchal as well as a professional perspective) had to be addressed fully so that it did not impinge on the quality of the data obtained or the willingness of the respondents to share information.

### **3.8.3 Obtaining informed consent**

Information sheets (Annex 2-7) were developed to introduce the salient features of my research, and translated, so that the participants read through it before giving their verbal consent and then signing the consent form (Annex 8-13). These consent forms were also translated to enhance understanding. The respondents who volunteered to be included in the project read and signed these forms. In order to break the ice and allay any fears, I engaged the respondents in conversation before and after the interviews and FGDs. As expected, I often needed extra time to clarify the concerns of respondents and discuss emerging themes with them.

## **3.9. Data Collection Methods**

I conducted both interviews and FGDs as these enabled me to explore the different “phases” of the LHWs’ lives. The individual interviews were mainly intended to probe in-depth into the respondents’ unique trajectories and career paths. The focus

was on their life experiences, education, upbringing, and the social context of the decisions and events that led them to become LHWs. The interviews generated data that was useful for examining how these women's personal and professional identities were shaped.

As a method that elicits more normative and consensual qualitative data, the FGDs focused on women's shared experience once they become LHWs; this included, for example, their professional socialisation as a work cadre through training, mentoring, supervision, field tasks, interaction with each other and with their superiors etc. The FGDs were particularly useful in generating data that helped address how community- and workplace-based gender dynamics influenced the LHWs' working practices.

### **3.9.1 Interviews**

Interviews are one of the most widely used data collection methods in qualitative research (Sandelowski, 2002, Fern, 1982). These are employed to collect detailed accounts of the participants' thoughts, attitudes, beliefs and knowledge pertaining to a given phenomenon (DiCicco-Bloom and Crabtree, 2006). The interviews are therefore suitable for gaining insight into the respondents' experiences (Silverman, 1993). It is assumed that the participants' statements about their experiences will reflect their reality if the questions are asked correctly (Morse, 2000) and that participants are able to answer them. Individual interviews contribute to eliciting in-depth data; however, at times the interviewee may withhold information or embellish if they wish to impress the interviewer (Fielding, 1994) or may volunteer information even though not asked for it (Padfield and Proctor, 1996). The social structural factors also influence the course and content of interviews (Manderson et al., 2006).

### **3.9.2 FGDs**

FGDs are an important qualitative data-gathering technique whereby data is collected through group interaction on a topic determined by the researcher (Hollander, 2004, Macdonald et al., 1997, Morgan, 1996). Since FGDs rely on interpersonal communication rather than one-to-one interaction, they can enable the identification of shared cultural values or group norms (Hughes and Dumont, 1993, Duggleby, 2005, Freeman, 2006).

FGDs have the advantage of providing each individual with an opportunity to respond to a question and share his or her experiences and point of view (Kitzinger, 1994), thereby enabling people to explore and clarify their views in a better manner than in one-to-one interviews (Kitzinger, 1995). It has been observed, however, that a group member's contribution to an FGD can be influenced by the views of other group members and the group effect (Carey, 1994, Carey and Smith, 1994). One advantage of this technique is that it offers valuable data about the extent of consensus and diversity among the participants (Krueger, 1993). Homogeneous groups are often considered a relatively safe environment in which to share experiences (Barbour, 2005).

### **3.9.3 Rationale for choice of methods: Interviews and focus group discussions**

The aim of including FGDs and interviews was not to cross-validate the information, but rather to illuminate different dimensions of women's experience as LHWs. The two methods were combined for data completeness and not for confirmation, as there is no implicit hierarchy of evidence, i.e. one method is not better than the other (Barbour, 1998). The rationale for combining the qualitative research methods is often for pragmatic reasons, namely having the ability to compare and contrast, and for data completeness and/or confirmation (Lambert and Loiselle, 2008). The data obtained through FGDs is different from that elicited during interviews. In individual interviews, each participant has one-to-one contact with the researcher, and thus there is no possibility of the other respondents influencing his or her answers or of the interviewee feeling the need to conform to the group.

Individual interviews also enable a more in-depth understanding of the participants' experiences. Unlike interviews, FGDs are limited in their potential for understanding individual thoughts, feelings and experiences, but are excellent for analysing the processes of group interaction. These processes stimulate memories, discussion, debate and disclosure in a way that is less likely in a one-to-one interview. In FGDs, the participants share views with each other; therefore, the type of information elicited is diverse.

Interviews allow more questions to be explored than FGDs, where fewer questions are discussed and the group co-constructs the meaning of phenomena. As the information in the FGDs is collaboratively produced, the group process and content around which this process is organised furnishes evidence at both the intrapersonal and intra-group level (Breakwell, 2006).

I was cognisant of the fact that individual experience may vary, contrast with, or conflict with group experience. I consequently expected differences and took these into account in my analysis. Any inconsistencies were not viewed as weakening the credibility of the results, but rather as offering opportunities for deeper insight into the relationship between the inquiry approach and the phenomena under investigation (Patton, 1999). In this research, these entailed a critical examination of how the constructs of professional identity and socialisation are enacted (or not) within this context.

#### **3.9.4 Process of data collection**

The field work was undertaken in two phases in 2013 and 2014. The first phase included the identification and finalisation of the field site and a reconnaissance overview of the NP, including its formative work. In this phase, I also prepared for the fieldwork of data collection that was to follow. Two interviews were conducted in a fifth union council to pre-test the interview guide. The guides for the interviews (Annex 8) and the FGDs (Annex 9) were translated and fine-tuned based on this round of data collection and analysis. The first phase informed a review of the research questions and a further alignment of data collection methods with the objectives of study. This also provided me with an opportunity to reflect and engage as a researcher in a more critical and culturally appropriate way in my study area. The phasing is shown below in Table No. 3.3.

**Table 3.3: Phasing of data collection**

Table 1: Phasing of data collection of study			
Method	Type of Respondent	# of Interviews	
		<b>Phase1</b>	<b>Phase 2</b>
Key Informant Interviews	District Health Managers (n=2)	1	1
	National Programme Managers (n=2)	1	1
	Health Facility Staff (n=2)	2	1
	LHWs (n=2)	2	2
In-depth Interviews			
	District Health Managers (n=3)	2	1
	National Programme Managers (n=3)	3	2
	Health Facility Staff (n=5)	2	3
	Vaccinators (n=3)	2	1
	LHWs (n=25)	13	15
Focus Group Sessions	LHWs	3	3

The interviews with LHWs were carried out at the health centres to which they were attached. The FGDs were also carried out in the health facility, as this was generally considered a neutral place and was favoured by the LHWs. Usually, the room in the health centres designated for LHW training and monthly meetings was used. It was ensured that health centre staff and other uninvolved people were not present, and no one could overhear the discussions. Multiple visits to the same union council were made for data collection. The managers were interviewed in their offices at their workplace. The health centre staff and those belonging to the field, including the NP staff, were interviewed in their offices or in their respective BHU or RHC.

### **3.9.5 Data collection topic guides**

Interviews were conducted using thematic topic guides prepared separately for interviews and FGDs (Annex 14-18). I only listed tentative areas of inquiry in the topic guides with prompts loosely around the subject. However, a list of key themes was prepared after every interview and FGD, which was used to revise the topic guide for further data collection. I prepared a list of questions and topics from general to specific; however, the interviewees were encouraged to express their ideas. This enriched the information obtained solely through a question guide. I conducted all of the interviews and facilitated all of the FGDs myself. On average, the duration of the FGDs was ninety minutes, while the interviews lasted sixty minutes. New developments during data collection also led to modifications and additions in the topic guide, e.g. the issue of the regularisation of LHWs, which is discussed in a later section.

### **3.9.6 Language and translation issues**

I interviewed all the respondents myself. Although I am fluent in Urdu, Punjabi and Potohari (the local dialect of Punjabi) and let the respondents decide which we spoke, Urdu was the predominant language of choice. Most of the respondents gave their interviews in Urdu, with the exception of two. One district health manager preferred to be interviewed in English, while one LHW opted for the Potohari dialect. All interviews and FGDs were tape-recorded with the respondents' prior written consent and permission. Despite my experience and medical background, I put in my best effort to adopt my PhD student identity. My previous community-based experience in primary healthcare in rural areas was very helpful, as was my training and experience in using qualitative research methods.

Translation was a key step in the overall research process. The consent forms and information sheets were translated, taking care not to lose the essence of what was being conveyed. The interviews were transcribed directly into English, while keeping some phrases or quotes in the original language. This was a very labour-intensive and time-consuming task. A few interviews were translated into Urdu, however, and then



retranslated into English. I used two bilingual individuals to troubleshoot problem areas in order to improve the rigour of my study.

### **3.10 Data organisation and management**

The data collection was staggered to allow for simultaneous transcription and initial analysis. I transcribed all of the tape-recorded interviews verbatim as soon as possible after the event. I listened to the audio recordings to see if they matched with the transcriptions to ensure accuracy. Indeed, I found listening to the audio files an invaluable step in the process of analysis for the duration of the study. Not only did I jot down notes as I listened, this also gave me the opportunity to relive the experience, which I found immensely beneficial in terms of analysis. I used NVivo Version 10 for data organisation and management, followed by analysis. I found that, although manual data analysis has no substitute, NVivo software cut down on the time and effort needed to retrieve specific sections of the data and also helped link up various sections. Using it from the start worked to my advantage, as I organised and managed my data through this software. Having little prior experience of managing a research project of this magnitude, I found the task daunting to a certain extent.

### **3.11 Data analysis**

Overall, I find it hard to put the activity of “making sense of data” in a timeline. Looking back, I cannot pinpoint when I started data analysis, for a significant portion of my thought process was engaged in this activity even while I was collecting data through the interviews and FGDs. However, I actively started data analysis after I had printed out the first few interviews transcripts. I had formatted the interviews and the FGDs in such a way that I could easily read them line by line as well as make my own remarks and notes in the margins. Along with reading, I also listened to the recordings of my interviews, listened to them again where and when this was needed at a later stage. This stage included a close reading of each text, which enabled me to garner an idea of the emerging themes.

In terms of research aims and the conceptual framework, I had three main categories: processional socialisation, practice and identity in addition to contextual factors like gender. I then uploaded my transcripts as an NVivo Project. I had initially coded these line by line, manually this led to more than a hundred codes per interview. I analysed the codes and, based on the similarities, reduced the overlaps and redundancy among them. This was a long iterative process as I did not want to lose the actual feel of this data. During the course of my work, I therefore turned to literature to for theoretical background and to see how others recommended approaching this kind of data. The conclusion I reached was that there was no single paradigm to answer every question, no short cut in other words.

Next, I listened to the audiotapes again, and made memo-notes on the printed transcripts as a way of clarifying my thought process. I found this memo-writing very helpful in organising my thoughts and making linkages between various themes. Finally, I settled for broad codes, linking them up with smaller sub-categories. As the data was collected in two phases, exploring the emerging themes in subsequent interviews and FGDs also helped alter the topic guide.

Consciously and subconsciously, I found myself employing the constant comparison method. A pattern started emerging when I compared the themes arising from the interviews of the health professionals with those of the LHWs. The multidimensionality of the data was a striking feature and the way two individuals saw the same thing from different vantage points made it all the more interesting.

Once my data collection was completed, I further refined my codes and, using the NVivo, I was able to code and recode and retrieve segments of the text for quotes.

**Table 3.4 Analytic dimensions and attributes of LHWs**

Analytic dimensions	Attributes
<b>1. Context</b>	<ul style="list-style-type: none"> <li>• Marital status</li> <li>• Education</li> <li>• Experience</li> <li>• Individual need</li> <li>• Previous employment</li> <li>• Job search</li> <li>• Desire to work in the years prior to joining</li> <li>• SES/Background</li> <li>• Family response</li> </ul>
<b>2. Socialisation</b>	<ul style="list-style-type: none"> <li>• Learning process</li> <li>• Experience of entry in field</li> <li>• Chaperoned during fieldwork</li> <li>• Registration of catchment area</li> <li>• Fieldwork perceived as</li> <li>• Work routine, i.e. scheduling activities</li> <li>• Differences in LHWs</li> <li>• Part of community</li> </ul>
<b>3. Practice</b>	<ul style="list-style-type: none"> <li>• Work routine, i.e. scheduling activities</li> <li>• Perceived differences in LHWs</li> <li>• Part of community</li> <li>• Interpersonal communication</li> <li>• Involvement in immunisation</li> <li>• Training perceived as</li> <li>• Trust of women in LHWs</li> <li>• Mode of referral of clients/patients</li> <li>• Linkages with <i>Dais</i></li> <li>• Nursing skills, i.e. BP, injections and infusions</li> <li>• Distribution of medicine</li> </ul>
<b>4. Identity</b>	<ul style="list-style-type: none"> <li>• Feeling like an LHW</li> <li>• Change in self</li> <li>• Affiliation with health facility</li> <li>• Accompanying patients</li> <li>• Affiliation with LHW supervisor</li> <li>• Work for or offer by private health practitioners to work for them</li> <li>• Confidentiality of clients</li> <li>• Education of children</li> </ul>

Matrices were developed for the emerging codes for the LHWs by including relevant text from the transcripts. These helped in analysing the spread of the data and even in cross comparisons.

Further analysis of these matrices also enabled me to organise the emerging codes. Along with coding and recoding the data, these matrices gave me better insight into the data, which led to a more advanced analysis.

### **3.12 Conclusion**

This chapter gives a brief over view of all the methodological aspects involved in the study, from inception of the research to report writing. A reflexive account of my own experiences is also given in addition to making all decisions taken transparent. In addition, I explain my epistemological stance underlying this research. All issues related to the design, preparation, sampling, data collection and analysis are explained along with the formalities such as development of consent form and field guides (Annex 19).

# **Chapter IV**

## **The Lady Health Workers in the making**

### **4.1 Introduction**

It has almost been a quarter of a century since the introduction of LHWs in Pakistan. In the beginning, novice women offered their services and joined this new cadre of health workers. In 1994, following their selection, the first cohort of LHWs was trained and then deployed in the community. In the coming years, many more women were inducted into service who subsequently embraced the role of health worker in their catchment area.

In the first section of this chapter, I will briefly introduce the study area along with a short description of the contextual factors highlighting the diversity in the LHWs' environment. The health workers were working in a patriarchal setup where access of women and children to health care services was compromised due many factors including the prevalent gender norms. The LHWs belonged to their communities and were strategically positioned at the interface of health care system and communities to improve maternal and child health.

The second section begins with the brief life histories of four LHWs, introducing who they are as well as how and why they embarked on this path. These narratives reveal some commonalties and differences among the LHWs, while also depicting the transformative changes these women experienced after becoming LHWs. The narratives of these four LHWs have been purposively chosen as a backdrop to this study to highlight the diversity among the LHWs.

In the third section I will examine the reasons why these women opted to become LHWs against the prevailing gender norms delineated by the patriarchal society in Pakistan. An overview of their educational experiences and past aspirations is presented. The LHWs perspectives on how and why they opted to become a LHW are also discussed. In the end a brief conclusion sums up the main findings of the chapter.

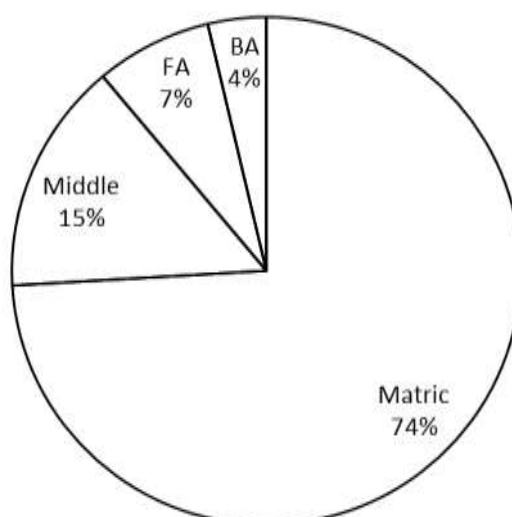
## **4.2 LHWs: The immediate context**

The study district comprised of both rural and peri-urban areas. In the latter, there has been a rapid influx of people from different parts of the country. This has resulted in densely populated suburban settlements, while villages are still predominantly local, i.e. residents living on their ancestral landholdings. The rural communities are relatively homogenous compared to the newly emerging settlements, where the incoming migrants include many different ethnic groups, e.g. Pashtuns in significant numbers. These demographic differences in the communities were also reflected in the distribution of LHWs there. In peri-urban settlements, most of the LHWs were migrants akin to their catchment population, while in rural areas, almost all were considered local by the virtue of their birth or family relationships. In peri-urban areas, LHWs belonged to the most numerous migrant groups in their catchment area. The LHWs in rural areas, on the other hand, belonged to their village, but were not necessarily from a numerically dominant group. Within the study area, only two Pashtun LHWs were working; one was deployed in an area where very few people shared her ethnicity.

The communities were patriarchal being patrilineal, patrilocal ensuring segregation and seclusion of females based on religion and tradition. It was mandatory for LHWs to reside in their catchment area. Almost half of the LHWs included in this study, especially those working in rural areas, were either local by virtue of being born in the area or considered as locals due to marriage with local men. Marriage within a family (mainly to cousins) was fairly common among LHWs. After marriage, many LHWs joined the extended families of their in-laws. Some LHWs arrived in their current catchment area from elsewhere, and were not considered local, despite having lived in their respective communities for a decade or more. Most of the LHWs lived in family-owned houses, with family structures varying between joint families (living with their in-laws in the same house) and nuclear families (living on their own). However, in the peri-urban areas only, many lived in rented accommodations. A considerable number of LHWs reported living in a joint family in the past, but then shifting to independent nuclear arrangements when they built or purchased a home of their own.

The majority of LHWs were married, as this marital status was a preferred criterion at the time of their selection and recruitment. Although there were some widows, their husbands were alive when they first joined the NP. A few single LHWs, who were either divorced or unmarried, were also part of this study. The mean age at joining was 29 years while means current age is 43 years and on average the work experience as LHWs was 14 years. The LHWs' educational levels varied, ranging from the minimum required level, i.e. middle grade (eight years of schooling) to graduation. The educational levels of the LHWs included in this study are shown in the following figure (Fig. 4.1).

**Figure 4.1 Educational levels of LHWs included in study<sup>5</sup>**



The LHWs working in the peri-urban areas possessed more education as compared with those in rural parts. In most cases, the LHWs' husbands were educated to the same level as their wives, sometimes even higher. Salaried jobs in the army, government and private offices were usually preferred by their husbands. Few had taken up private jobs such as painters, petty contractors, security supervisors, mason and drivers. Farming was a rare occupation among these men. Many husbands were reemployed after retiring from the army as soldiers. The men were breadwinners of the families as there was a clear division of labour based on gender norms. The

<sup>5</sup> Middle 8, Matric 10, FA 12 and BA 14 years schooling.

women were however, confined to their houses and household related tasks and primarily involved in unpaid work. Therefore, a husband's inability to earn a living was frequently reported by the LHWs as the primary reason for their becoming LHWs. The underlying reason for this predicament was ill health of their husbands due to heart ailments, kidney failure or mental health issues. Although their socioeconomic background was diverse, the majority of women included in the study were hard-pressed financially. Nearly all of the married LHWs had children, ranging from very young to adults, and most of them were studying.

The LHWs' homes were designated as "Health Houses" and varied in distance from their local healthcare facility, ranging from 0.25 kilometers to ten kilometers. However, on average, the reported travelling time was roughly half an hour on foot. Most LHWs stated that they were able to cover the houses in their catchment area through half-hour walks. If they could not, this was due to the population being sparse and widely scattered, which took a lot longer to cover.

### **4.3 Introducing LHWs**

Twenty four LHWs shared their life experiences with me during the interviews, and the following four narratives provide insight into who these women were and why they adopted the role of health worker. By introducing a few select LHWs, I seek to provide a context for further mapping the life trajectories of LHWs. The LHWs whose narratives are described below belonged to different areas included in this study. Three of these women come from rural communities while one belongs to an emerging peri-urban settlement. All four possess more than twenty years of work experience, as they joined the initial cohorts of the NP, around the mid 1990s. The narratives of these LHWs were chosen as they point towards the diversity amongst the LHWs included in this study.

#### **4.3.1 Mehtab:<sup>6</sup> quest for survival**

Mehtab (MB), a fifty-two-year-old widow working since 1996, has been a resident of her catchment area since her marriage in 1990. Having studied till eighth grade, she is now the sole earner in her family. Her husband died four years ago after a protracted

---

<sup>6</sup> I have given each LHW interviewed a pseudonym.



mental illness, which had prevented him from continuing his job as a labourer. Mehtab lives in her own house and owns some farmland. Her catchment area is large and consists of small hamlets amidst fields and foothills. The nearest main city and Basic Health Unit (BHU) are twenty-eight kilometers and five kilometers away, respectively. The catchment population in her area is local and generally illiterate and poor. There are no healthcare providers in her community. The nearest private health facilities are about fifteen kilometers from her village, while the public-sector hospitals are located even further away, about thirty kilometers in the city.

Mehtab became an LHW out of “majboori” [necessity], primarily in order to make ends meet. She reportedly did not face any difficulties either in the initial training or subsequently in field. At the outset she was accompanied by her daughters for support in the field. The latter have no objection to her continuing with the job, but now feel shy and do not accompany her anymore. Since becoming an LHW, Mehtab has felt a change in the way she spends her time in the community. She rarely left the house prior to becoming a LHW, but now she has to venture out frequently as a part of her job. Over the years, despite starting off as a housewife, she considered herself different from other women around her.

*“There is a huge difference between me and other women in my village; they look after animals, farms and pursue only house chores while I visit the Health Centre and all households in my area as part of my work”.*

*(MB, 52 years, LHW rural, 1996)*

Mehtab still needs her supervisor’s support for the completion of routine tasks like conducting household visits and filling in patient registers. After putting in a lot of effort to improve her writing, Mehtab is now able to manage some of her paperwork alone. Due to her poor writing skills, Mehtab’s supervisor advised her to get her daughter who had passed the Matric<sup>7</sup> inducted as an LHW in her place; the daughter

---

<sup>7</sup> Certificate for completing ten years of secondary school

declined the offer as she did not desire such a job unless there was a dire need. Methab feels her work is “not bad and is good enough”. However, she only continues her job due to a lack of other means of livelihood. This job not only allows her to meet her expenses, but has also elevated her standing in the family as a result of her financial independence.

Mehtab perceives that her community values her services as she distributes medicine and facilitates mother and child immunizations. She believes that, although she might be less educated and therefore “less fashionable in terms of dress and getup compared with other LHWs”, her quality of work is second to none. In her view, there are no differences between the LHWs due to experience or education. She enjoys a mutually respectful relationship with her fellow LHWs and the BHU staff. Mehtab is less educated and her financial needs remain as before she continues to support her family as a sole bread earner. She however, has not been able to upscale her work skills.

#### **4.3.2 Khalida: A pioneer LHW**

Khalida (KA) is a fifty-four-year-old married LHW who joined the pioneer batch in 1995. She attended school in her own catchment area and successfully completed the Matric. Among her five grown up children, there are two daughters who have completed master’s degrees, while her husband is a retired office worker. Her catchment population is comprised of local residents. The men in her village work in cities and many serve in the army. In recent years they have increasingly sought work in nearby government organizations. Local farmlands are being used for crops, poultry and cattle farming. Khalida’s home is only half a kilometer away from the BHU, but thirty kilometers from the city. Her village has good road connections, however, which allow the residents to commute easily to the city for work and other needs. There are a couple of informal health practitioners in the area. About fifteen kilometers away from the village there are numerous private health practitioners, while in the nearby city, public-sector tertiary healthcare facilities abound.

When Khalida learned about the LHW job vacancy, she was a housewife, confined to her home. Since she fulfilled the recruitment criteria for the LHW and the work seemed interesting, she decided to give it a try. In the absence of any other candidate

from her village, she was easily selected. When Khalida joined the NP, her family was facing financial hardships. At that juncture, even the initial paltry stipend mattered to her. Due to her job, the financial burden on her family was reduced, and the education of her children made possible. She considers herself part of her community as well as that of Health Centre but still has her doubts regarding the later.

*“It often crosses our mind that we are still not a regular part of the health department! Somehow it’s a feeling of being taken for granted.”*

*(KA, 54 years, LHW rural, 1995)*

While undergoing the initial training, Khalida dreaded conducting household visits. She still vividly remembers her anxiety at the commencement of her fieldwork. In the beginning, people would not allow her to enter their homes. Through the facilitation of the community members, however, she ultimately gained entry into these households. She joined the NP after gaining permission from her husband, who had initially encouraged her to apply for the job. Once she commenced her fieldwork, however, he showed serious concern regarding her household visits. However, over the years, his opposition receded. For the first few years, she used to take her young sons along.

Over time, Khalida has motivated the members of her community to look after their health through raising awareness. She also provides health services to women in their homes, including the distribution of contraceptives and medicine. She now holds a good *mukam* [standing] in her community, and is given a lot of *izzat* [respect], since her community believes she works for its well-being.

#### **4.3.3 Sughra: LHW with an ambition**

Sughra (SU) is forty-one years old and married. She has been working as a LHW since 1996. Her hometown is three hours’ drive from her current catchment area, where she studied till grade ten as a regular student and later finished her bachelor’s degree as a distance learning candidate. Before this job, she also taught in a school for two years in her village, and later in the neighbouring city. Her husband previously

worked as a mason, but is now a telephone operator. She has three young children, who are enrolled in school. She lives in a peri-urban area gradually transforming into an emerging town about fifteen kilometers from the main city. Due to its close proximity, Sughra's community benefits from the city's roads and other basic infrastructure. The community is a mix of old inhabitants and new residents, most of whom possess low socioeconomic status. Her catchment area is about four kilometers from the Rural Health Centre (RHC). There are many formal and informal private healthcare providers and hospitals in the area, and numerous secondary and tertiary healthcare facilities in the nearby city.

Sughra was introduced to the NP by her sister, whose private school was visited by an LHW inviting women to join. Being unmarried, Sughra's sister was not eligible and she referred Sughra for this job. The LHW's job required permanent residence in the area, so Sughra moved from her husband's house in the neighbouring city to her mother's home, a decision opposed by her husband. Now she is permanently settled in her newly constructed house built on land gifted by her mother. When Sughra joined the training, her son was only one month old. She had a dire financial *majboori* [need], which led her to pursue this job. Despite facing a lot of problems initially, she managed to continue as an LHW due to the support extended by her parents and sisters. She feels that, even in the beginning, she was too committed to her work and prioritized it over and above everything else, including looking after her own children.

At the outset, Sughra took her sister along for field visits as she was afraid and did not know the people. Her sister, on the other hand, was well-known by virtue of being a teacher in the local school. At the beginning, people either would not open the door or made enquiries, asking Sughra who she was, how long she had been working and where she came from. They suspected her of being from the family planning department. It took her months to get accepted by the community and she recalls it as a daunting task.

Sughra's financial situation has improved considerably, along with her freedom to spend the money she earns. She has no *mohtaji* [dependence] on others; nobody asks how she spends her earnings, and she is also in a position to give loans. She pays her

children's fees as well as all of her household expenses. Her husband willingly gives her the money that he earns along with the freedom to use it as she pleases.

She still works within the ambit of her assigned tasks and avoids activities that are not in her purview.

*“The truth is I do not have interest in giving injections. I am afraid and moreover, we do not have permission for this. This is not a mandatory task but if I am ordered strictly I will give injections. This does not mean I do not know how to give injections as in the recent measles campaign I immunized about 400 children”.*

*(SU, 41 years, LHW peri-urban, 1996)*

After becoming an LHW, she feels she has mastered the art of speaking and developed more *shaur* [awareness]. Now, regardless of the situation, she can speak confidently and convey all types of health messages.

#### **4.3.4 Nasreen: Mastering life and work skills**

Nasreen (NA) has been an LHW for the last twenty years. Nasreen's village is an old rural settlement surrounded by agricultural fields, thirty-five kilometers from the city but well connected to it through a good road link. The residents are mostly local and poor, with the majority of men serving in or having retired from the rank and file of the army. The BHU is only four kilometers away from Nasreen's catchment area. There are a couple of informal health practitioners near her village, and over the years she has maintained a working relationship with them. There are numerous private-sector health facilities about ten kilometers away, while the public-sector hospitals are located in the nearby city.

Nasreen is now fifty-one, married and a mother of five grown-up children. She was born and brought up in an area about five to six hours drive away from her current catchment area, where she arrived after marriage. In her school life, Nasreen was part of her school's debating team. She passed eighth grade, but could not successfully

complete her Matric examination. However, all five of her children have done well in their studies; the older three have completed university degrees. Her husband has now retired from the army and she lives with him, her children and her mother-in-law. Becoming an LHW has positively influenced her relationship with her mother-in-law, who is now full of praise for Nasreen's work as an LHW and for the way she has raised her children.

Arriving as a young bride in her husband's village was a major event in Nasreen's life. At the young age of twenty, she could not comprehend the local dialect or culture. In her paternal home, Purdah was observed and Nasreen's only visits outside were those to school. When Nasreen arrived in her husband's village, her mother-in-law tasked her with outside household chores, which posed a problem for her. Here, the village women rarely used the veil, and Nasreen stood out because she wore a burka<sup>8</sup>. Finally, she decided to forego the burka, several years before becoming an LHW.

When applying for the job in response to the newspaper advertisement, Nasreen was not aware of the true nature of the job except that it was health related. At that stage, the main impetus behind her application was to earn money, although some element of helping women was also at the back of her mind. She regarded her experience of initial training beneficial as this considerably increased her knowledge. When Nasreen commenced her work in 1996, she was assigned to two villages, her own and another adjoining hamlet where the position of LHW was vacant. She feels she was successful in her efforts in both these villages.

Nasreen believes that being an LHW gives meaning to her life. She has always worked with conviction, and the stipend has helped her meet her financial needs. Her family was undergoing a financial crisis in the mid 1990s, and she gained a lot of *izzat* [respect] and self-reliance from her earnings. Educating her children was a priority for her, so a major portion of her stipend was taken up by their educational expenses.

---

<sup>8</sup> An enveloping outer garment worn by women in Islamic countries to cover their body and face in public.

Now her son is working overseas as an engineer and earning a good salary; he has consequently advised Nasreen to quit her job as an LHW. She is not interested in leaving her job, however, as her earnings were crucial in times of familial need. She does recognize, though that the stipend she receives is not commensurate with her efforts.

Her existing work-life amalgam suits her as she conducts field visits along with pursuing her household chores. Nasreen's work also enables her to fulfil her social responsibilities as a member of her community. In 1998, she was honoured with the best LHW award in the district. In recognition of her skills, she was also offered a job by a private practitioner in a hospital, but she declined the offer. Nasreen feels that over the years she has developed professionally and expects other LHWs to be able to perform basic nursing tasks like her. She considers LHWs the backbone of their communities.

*If you ask me LHWs are a superpower in their communities' sehat keh hawalaeh seh [from a health point of view].*

*(NA, 51, LHW rural, 1996)*

As described above, the positioning of LHWs in terms of their origin, upbringing and personal circumstances has influence on why and how they adopt the role of health worker. These narratives furnish an insight into LHWs' perspectives on their social pathways and transformation into health workers, which, in turn, provide context for a broader picture of the personal and professional trajectories of LHWs. In the last two decades, LHWs have undergone transformative changes in their personal selves, which have had a spill over effect on their families and households. The preceding four narratives introduced the LHWs as individuals rather than merely as health functionaries. All the women were facing financial problems when they joined the NP. They benefited from their earnings, which enabled them to improve their socioeconomic condition and standing in their communities. The initial challenges they confronted were surmounted through personal change and agency, the extent of which varied from one LHW to another. Becoming LHWs was an unexpected 'once in a lifetime' opportunity for most of these women as, most of them had never dreamt

of adopting such a role in their life. The socialization of these women as health workers brought about changes in them which subsequently led to development of their identity. This transformative process occurred within a patriarchal environment and suggests a sense of agency of the LHWs or what feminists have called the power within.

#### **4.4 Education and early career aspirations of LHWs**

All the LHWs involved in the study attended public schools in their home towns, a majority for ten years, i.e. Matric. A few could not pass the Matric examinations and therefore only possessed middle standard certificates. Only three LHWs continued their education to graduation. Some attended schools in large cities like Islamabad, Karachi and Rawalpindi, but most of the LHWs pursued their schooling in small towns and villages. Some LHWs spoke of the difficulties and problems they faced in order to pursue their education, as they belonged to households or communities where educating girls was not considered a priority as women were considered only as homemakers due to prevailing gender norms. This decision lied with the family who were more inclined to marry the girls as early as possible according to the societal norms. Therefore, in areas where LHWs were introduced, households laid less emphasis on the education of their girls expecting their primary job to contribute towards household work and therefore many could not pursue their education properly.

*The village is still mostly illiterate, but in our childhood, it was even worse and more so for the education of girls. I wanted to become a doctor, but no one paid any attention, I ended up with an arts education, that too due to my own efforts. My parents also did not show any interest in my education. I used to help with household chores and my mother used to keep me away from school whenever there were things to be done.*

*(RS, 35, LHW rural, 2009)*

There was reluctance on part of parents to send their girls to school, especially where girls and boys studied together as segregation of sexes was high on the social agenda. In rural areas and urban poor most of the girls were not allowed to continue education after middle standard or Matric. Their marriage was arranged and girls did not have



any other option as this strategic decision was taken by the parents and their families on their behalf. This was also true in case of most of the women joining as LHWs. A LHW faced these challenges while pursuing her studies, but was still able to complete the Matric by chance and against all odds.

*In my village, both girls and boys studied together in the same primary school. There is only a boy's secondary school in the area, therefore; most of the girls leave education after primary schooling. I was the youngest of six siblings; my brother went to school while sisters didn't. My father was reluctant to send me to a mixed primary school. My opportunity came when I left my parents' house to live with my eldest sister in another village as she needed a helping hand during her pregnancy. I completed primary schooling in her village with good marks. I was able to complete the Matric while staying with my sister, being the first girl in my village to do so. My elder brother forced my parents to cut my education short and soon thereafter, I was married!*

*(SH, 38, LHW peri-urban, 2007)*

Many of the LHWs interviewed recollected their desires and expectations while studying at school. Several had to quit their education soon after completing the Matric in order to get married and start a new life according to the prevailing norms. However, many LHWs shared their original desire to become teachers and a few even completed a Primary Teachers Course (PTC), while there were others who wanted to do the same, but could not due to their early marriage and subsequent domestic responsibilities. The marriage arrangements being patrilocal the girls after marriage moved to their husband's house and this was a turning point in their lives. They could not continue their education and became busy in the household chores and other social responsibilities. Even if the parents wanted their daughters to continue their education, countering the prevalent peer pressure was difficult. A few had high expectations, but as described below family conditions impinged upon these.

*I completed the Matric at the boy's secondary school in my area. At that time my wish was to work as a teacher. It is a thing of nasib [fate] that my wish was not fulfilled. Many families came with rishta [marriage proposals] for me; however; my mother told them that she would only marry me after I completed twelfth grade, followed by a PTC from Allama Iqbal Open University (distance learning). "After my daughter becomes a teacher I will marry her". I was engaged after larie jaghra [fighting] in the family, and got married as my in-laws pressed hard for marriage. Unfortunately, I could not pursue a PTC*

*course due to domestic responsibilities as my old mother-in-law could not manage the house.*

*(SP, 38, LHW rural, 1999)*

While most of the LHWs thought about teaching as a career, there were a few who wanted to become doctors or nurses. LHW Sughra even joined high school for this purpose, but could not make it. However, she continued to study and completed her bachelor's degree through her persistence.

One of the LHWs wanted to become a nurse as her mother was a midwife, but she was married soon after her Matric. Many others were also interested in pursuing medical education, but had to give up on the idea due to the social and financial circumstances in their family. A couple of them undertook a teacher's training course instead and even taught in private schools. Several LHWs, including Mehtab, Khalida and Nasreen, were only concerned with studying while attending school and did not have any expectations beyond that. Three of the LHWs interviewed had been running adult literacy centers while staying in their homes, funded by a government initiative, prior to joining the NP as LHWs. The main driver among these women was pursuing a career as a teacher, the latter being a socially acceptable profession in their communities and within the acceptable gender norms.

In case of most of the LHWs their parents decided on their strategic life choices. This meant their education was discontinued after high school and they were married soon after. These decisions were primarily based on the prevailing gender norms of gender segregation, restrictions on mobility of women and gendered division of labour. Furthermore, women's honour and place was considered in their homes rather than outside. The LHWs incidentally came across another strategic choice in their life after their marriage i.e. opportunity to join as an LHW. At this juncture the power to decide transferred from their parents mainly to their husbands. Nonetheless, they joined as LHWs however, this being a new and unique undertaking as an anticipatory socialisation phase was missing when compared with other professions.

#### 4.5 Looking for job seekers?

There were no community-based health workers when the initial cohorts of LHWs were introduced in the mid-1990s. Advertisements for recruiting LHWs were run in local newspapers to inform the public of this new opportunity and to invite applications from prospective candidates. The response was poor, as women did not come forward in large numbers. Therefore, the staff of existing healthcare facilities took it upon themselves to persuade local communities to help recruit health workers. They were successful in their endeavours to some extent, as, despite initial hesitation, some pioneer women accepted the challenge. Even when the second phase was launched in 1996, the true nature of the LHW job was still unclear. LHWs belonging to the first cohort had been deployed in the field, but this cadre was small in number and not yet on firm footings or visible on the scene.

In the beginning, many women approached the health facility after hearing about the LHW opportunity through word of mouth or through the official advertisements in newspapers. As Mehtab recalls, she was already looking for a job due to financial problems as her husband was mentally ill. She had only eight years of schooling and was desperate for employment to meet the subsistence needs of her family.

*I came to know through hearsay that the health centre was recruiting women. I went to the BHU and inquired about the job. They said if I wanted to get this job I should apply. I filed my application and fortunately was selected.*

*(MB, 52, LHW rural, 1996)*

Nasreen learned about the job from the newspaper, while Khalida and Sughra's source of information was their near relatives, i.e. husband and sister respectively. Another woman was proactively looking for a teaching job and her search accidentally culminated in her becoming an LHW, despite belonging to a very conservative household.

*I was confined to my house as a lot of attention was given to purdah in my family. I never used to visit other houses. Actually, I wanted to join an adult education school as I was lonely at home. My husband took me to the Union Council office and inquired about teaching jobs in schools. They instead*

*referred us to the health centre, where we were told that they did not offer adult education but did need an LHW from my community. My husband gave permission so I joined this job.*

*(SM, LHW rural, 2003)*

As time passed and the position of LHW became more established, women began to purposively seek opportunities to work as LHWs, as the job seemed like an attractive opening for women who wanted to work near their homes. Many of the women in the later cohorts of LHWs fall into this category. Many of them had been in contact with the health centre or other LHWs prior to joining the NP as health workers. One woman had applied thrice for the job of LHW in her native village without success. She was ultimately selected as an LHW in this district after waiting for almost three years. Another woman's relative was already an LHW, and she followed up with her contact for a potential vacancy for quite some time.

*When unmarried I taught in a school for seven years. I got married to my cousin and moved to his village. There, I had an urge to do something and wanted to escape the monotony. I sold my jewellery, bought land and built a house here. I taught for two years, but was desperately looking for alternate work. One of my relative was an LHW, I frequently asked her to inform me when there was a vacancy. Before my marriage I thought this is Dai's [TBA's] work and thus did not hold a good impression.*

*(AI, 36, LHW peri-urban, 2007)*

When the NP was launched, the minimum educational requirement for selection of an LHW was middle standard, i.e. eight years of schooling. This criterion remained unchanged during the subsequent phases of LHWs. With the passage of time, however, more educated women became interested in becoming LHWs. There were even a few women with fourteen years of education who were working in the field as an LHW.

Initially, some of the LHWs quit as health workers to become teachers, but in later cohorts, many shifted from teaching in the private sector to the role of health worker. Thus many women who joined as LHWs in later phases were employed as teachers in private schools before joining the NP and possessed prior teaching experience. These women quit teaching because of the working conditions in schools. Compared with

their current job as a LHW, school teaching involved less remuneration and less flexibility in working hours. Some women also quit teaching due to their personal circumstances, e.g. one woman made the switch to LHW because she needed flexible working hours to be able to look after a disabled relative.

Among the later cohorts, the LHWs themselves influenced and encouraged their acquaintances to join the NP. Inspired by one of her relatives who worked as an LHW, a woman took up her place when the former moved from her area. Many women had previously lived in the catchment areas of other LHWs, and had met the LHWs in their neighbourhood before they joined as a LHW. This contact, although cursory, was enough to influence these women to join the NP. In other instances, LHWs spotted eligible women in their community and informed or encouraged them to become LHWs.

One woman who had just completed school in 1998 and joined the NP thereafter was influenced by one of her relatives to become an LHW in order to overcome the need for a chaperone.

*My husband's aunt lives in an adjoining village and wanted to join as an LHW, but she was not allowed to work alone. She asked me to join as a health worker as there was a vacancy in my area. That would mean she would also get permission to work as an LHW; that is exactly what happened!*

*(SZ, 36, LHW rural, 1999)*

There were different sources of information for women who were interested in becoming LHWs. These changed overtime from a more arbitrary one in initial cohorts to interaction with the LHWs already working in their communities. The LHWs in the latter phases were well aware of the strategic choice of becoming a LHW as the cadre was already working in their neighbourhoods. The household members of potential LHWs also had better idea about the roles and responsibilities of the CHWs as they came across them in their communities.

## 4.6 Why join as a health worker?

The primary responsibility of the women in the study area was domestic work. Men were the sole breadwinners in the household and ventured outside to work, while women were mostly confined to their homes. In addition, women in rural areas used to lend a helping hand in the fields and in caring for the animals. Needy women living in peri-urban areas sometimes worked as domestic help locally or in nearby cities. A few taught in local public schools; however, the majority of the teachers came from outside the district. Having acquired an education, women took up teaching as an interim career while waiting to get married, with no intention of continuing with this profession. Within this context, joining the NP and serving as LHWs outside their homes represented a huge change and transition in the lives of these women.

Initially, health managers and health centre staff faced difficulties in recruiting LHWs from highly patriarchal communities. The communities were reluctant to commit to this service, despite the presence of a large pool of potential candidates as the whole concept was in sharp contrast to the gender norms. In the communities there was separation of men and women into almost mutually exclusive arenas of social interaction. A rigid gender based divisions of labour existed and mobility of women outside their homes was quite restricted. After a concerted effort by health centre staff and managers, women were gradually convinced to join, to be selected and trained as LHWs. While reflecting on their life trajectories, it is important to understand why women chose this role in the first place. The introduction of LHWs into communities where women seldom pursued paid work was an innovative undertaking. In the mid1990s, women who fulfilled the eligibility criteria and were willing to work as LHWs were not aware of any such precedent, either in their own community or in the areas around them.

There were many reasons why women chose to become LHWs. The three foremost reasons that emerged from their narratives included *majboori*, an Urdu term commonly used to refer to a state of necessity, constraint, compulsion and helplessness usually beyond an individual's control. Another somewhat contrasting

term LHWs used consistently in their narratives was *shauk*, which means interest in something that is within one's own ambit. The third reason cited was *khidmat*, meaning 'to serve and contribute'.

When women joined the NP in its initial phases, they did not know what they were opting for, while those in later phases had already observed LHWs working in their community. The latter were therefore in a better position to decide whether or not to become health workers. The LHWs who joined in later cohorts were consequently more explicit regarding their reasons for deciding to become an LHW i.e. mainly as a source of income.

#### **4.6.1 Majboori**

The foremost reason cited by women underlying their decision to become an LHW was financial need, which they described as their *majboori*. A pioneer LHW summed up the issue as follows:

*I believe no one ventures out of their house in the absence of majboori. Of course there are other reasons, but majboori always takes priority, doesn't it? It is majboori that makes people go out and look for work.*

*(FA, 52, LHW peri-urban, 1995)*

Mehtab direly needed money for food because of her husband's unemployment due to ill health, and she was desperately looking for a job while living in a remote rural village in the mid 1990s. Mehtab confided that she is still working for the same reason. She continues to do it solely because of her persisting necessity. Many other LHWs were similarly facing severe financial difficulties and needed a means of earning to sustain their families. In the absence of any social support systems, the LHW job was their lifeline. One LHW joined when she was a very young girl still studying in school. As an orphan, she had no other source of income and was, moreover; looking after her siblings.

*RA: I was studying in ninth grade when I joined as a LHW because of majboori.*

*AW: Both her parents had died and she had to take care of her young brothers and sisters and that is why she started, and later on got married so she found a means of livelihood as an LHW.*

*(FGD, LHWs rural)*

In the initial phases of the NP, *majboori* was cited as a major factor in a woman's decision to become an LHW. However, many women who recently joined as LHWs also reported being driven by poverty due to their husbands' joblessness or sickness. This income lent a much needed helping hand in their household expenses. Given the patriarchal nature of Pakistani society, it was especially helpful in cases of where the sole male breadwinner of the family suffered ill health.

*My husband was suffering from TB. I did not have many options due to a lack of formal education. As soon as I came to know LHWs were being recruited, I offered my services as an LHW.*

*(SK, 41, LHW peri-urban 1998)*

Another woman quit her teaching job to look after her sister-in-law and joined the NP as an LHW as her husband was unemployed.

*I was needy and wanted to pursue some work, alongside of which I would be able to look after my disabled sister-in-law. I also needed money as my husband was not working. I thought (to myself), "Why I should not join as an LHW".*

*(TM, 40, LHW rural, 2009)*

A few women were facing financial hardship as their husbands could not find work and thus they decided to become LHWs. They also explored a variety of other options to raise money to meet their household expenses.

*I joined as an LHW due to necessity. I direly needed financial support as my husband was unemployed. I was facing major financial difficulties at that time. I was looking for additional sources of income and therefore, I kept chickens, followed by goats, somehow I managed my household and even worked in a surgeon's private clinic.*

*(RY, 37, LHW peri-rural, 1998)*



In case of LHWs who had only completed the middle-grade standard of school, finding a job was next to impossible. Therefore, they gladly availed themselves of this opportunity. An LHW who joined in the last cohort in 2009 candidly expressed her *majboori* as her reason for signing up.

*The reasons behind becoming an LHW were my family problems. I had little education and numerous domestic problems bus ghurbaht thee [there was abject poverty] .....[Sigh.....] These days this is the thing!*

*(MR, 28, LHW rural, 2009)*

For many LHWs, their existing household earnings were insufficient and their stipend supplemented other sources of income available to meet their household expenses. Women joining the NP needed funds not only for these expenses, but also for their children's education. Although the stipend was minimal, these women still considered it sufficient enough to join and serve as LHWs because of their prevailing circumstances. The LHW's job appeared attractive to many needy women who otherwise could not have gotten a position traditionally open to women in the study area, e.g. teaching, as this required higher educational credentials. Similar to others, Sughra also became an LHW out of *majboori*. According to her, the conditions were such that she had to get a job, otherwise *guzara* [sustenance] was difficult, even though she was already teaching in a private school before she became an LHW. Another young LHW working in a rural area joined the NP because she anticipated financial issues in her husband's home after her marriage due to his unemployment.

The underlying reason for the decision to join the NP differed amongst many LHWs whose husbands were self-employed or working in offices. In such households, with dual sources of earning, the LHW stipend contributed towards the household expenses. In the case of Nasreen and Khalida, their husbands were salaried employees. However, their incomes were not sufficient to fund their children's educational expenses. This was also true of other LHWs who, despite their dire circumstances, were keen to provide their children with a good education and therefore worked in private clinics to supplement their income to be able to do this. The following quote depicts how the motivation for children's education drew women like Khalida towards this job.

*I thought the financial problems we were facing would lessen. Although the monthly stipend was only 1200 rupees at that time, even that mattered. The burden on our shoulders was lightened a bit as the expenses for school fees and books for our children had always been difficult to meet.*

*(KA, 54, LHW rural, 1995)*

The financial need was the single most important factor why women decided and were allowed to join as LHWs. This also mellowed down the reservations of their families to conform to the deeply entrenched gender norms of their communities which were in sharp contrast to the NP requirements of their health workers.

#### **4.6.2 Khidmat: Serving the community,**

As described earlier, the major impetus for deciding to join the NP as LHWs was women's financial need. Another key influence that played a role in this decision was the desire to serve their community. Different motivations were cited by the respondents, such as *jazba* (enthusiasm or passion to serve) or *khidmat* (serving). A general concern for their community was another strong motivation behind these women's decision, and many were influenced by problems related to the lack of available health services in their community. In addition to the health facilities being inaccessible and underutilized, community awareness regarding health problems was also perceived as low by the LHWs. The views of one LHW who joined in 1998 illustrate this line of thinking.

*I observed there were many problems, like children in my village were not getting vaccinated by the parents. Some people in the village possess jazba [enthusiasm] to bring about a change. I thought I could do something for my village. My education was to Matric level and after giving it a good thought, I joined as an LHW.*

*(FB, 47, LHW rural, 1998)*

The women in the study area were often unable to access health services due to gender-related issues. Some of them attributed their motivation and decision to join as LHWs to their own life experiences. Some women, for example, had personally faced barriers to accessing family planning and MCH services. As one said:

*The women in my village faced problems, especially in birth spacing injections. I used to visit for family planning injections, accompanied by my mother. We had to go to a far-off place, and it was really difficult. Few women could go that far, but there were many who could not even get out of their homes. That is why I decided to become an LHW, as I had personally faced these problems.*

*(RS, 36, LHW rural, 2009)*

Accessing health services for pregnant women and for children needing immunizations posed a lot of problems that many women personally experienced. The desire to alleviate these problems in the community motivated many women among the group to offer their services as LHWs. The actual physical difficulty of reaching distant healthcare facilities was not the only motivation for joining, however. Many of these women were also driven by a desire to overcome the social and gender-related barriers that blocked them and others from accessing health services.

*I became an LHW because women often face numerous difficulties. There have been times when I had no support and did not know what to do or where to get support. There are so many women who cannot go to hospital, as they live far away from the health centre. They are not sure if they will be helped by their husband, or parents-in-law, and they cannot even voice their needs. I joined so that I can listen to them and help them.*

*(SH, 38, LHW peri-urban, 2009)*

The women joined as LHWs to serve their communities and alleviate the sufferings of their fellow women. The reasons cited by LHWs were based in the way the communities were structured around the gender norms which delineated what was acceptable or not for the women.

#### **4.6.3 Shauk: The interest to do something**

Some of the LHWs cited *shauk*, which means “the interest to do something”, as their main reason for joining. Often *shauk* was translated as an eagerness and desire to serve people. Said one woman:

*I joined due to shauk. I had shauk to do some work in my area, especially welfare work, so that I could meet people and make a meaningful connection with them. I still work with shauk.*

*(GB, 34, LHW rural, 2009)*

This feeling also helped women to overcome the resistance they faced from influential family members about their decision to join the NP as LHWs. As one LHW said, it was her interest that enabled her to overcome her brothers' opposition.

*I started with my shauk, and no one in my family approved. Rather, my brothers were totally against this, but I stuck with my shauk. I told them, "My husband is giving permission. I used to be your responsibility, but now I am his [my husband's]" and I joined as an LHW. My shauk is still there even today, even though I myself have aged considerably.*

*(AW, 41, LHW rural, 2009)*

In many cases, it was *majboori* coupled with *shauk* that motivated women to become LHWs. One woman, who belonged to the pioneer cohort of LHWs, said:

*I had shauk, and personal financial needs were also there. I had always thought for a long time that somehow I could do this type of work, but I did not have the resources. When the NP was introduced in 1995, I applied feeling, I can do something. I started and my interest grew and I worked wholeheartedly for my own satisfaction.*

*(PA, 55, LHW peri-urban, 1995)*

Many LHWs developed an interest in their job even before they joined the NP as health workers. Although Khalida joined out of *majboori*, she quickly became interested in learning more about the job that would enable her to contribute to her community. For many LHWs, it took some time to develop *shauk*, as this was not the primary motivation at the time of their induction. Regardless of their initial motivation, however, many LHWs developed an interest in their work with the passage of time. Some started out of need, but continued afterwards, despite changes in their situation, because of *shauk*.

*First it was majboori, and now I have shauk. I was studying in the school and was unmarried for the initial three years of my job. Being unmarried, people did not trust me. Going to the households on my own was an issue and I*

*hesitated to give advice. After my marriage, I developed shauk. I do not feel the majboori anymore, unlike in the past, when I was supporting my younger siblings and was also reluctant to visit houses.*

*(RA, 37, LHW rural, 1998)*

There were many reasons for joining and working as LHWs in the communities. The division of labour in the communities where LHWs are working is based on the patriarchal gender norms. The men are the breadwinners while the women are confined to their homes and mostly involved in unpaid work. The prevailing norms relating to women's mobility are closely linked to notions of segregation and honour culminating in seclusion of women. In these circumstances as we have seen, *majboori* was the primary factor in the LHWs' decision to join the NP. Other factors, such as *shauk*, *jazba* and *khidmat*, also emerged as secondary reasons in the LHWs' narratives. These might be retrospective afterthoughts and explanations to justify or rationalize their decision based on their lived experiences following their socialization and work practices.

#### **4.7 Conclusion**

The first cohort of LHWs was trained and deployed in the district in 1995. Initially the introduction of an exclusive cadre of female health workers was a huge challenge. However, overtime several cohorts were recruited in the district the last batch being inducted in year 2009. The patriarchal context and poor socio-economical conditions in the rural and peri-urban communities was the immediate context of the lay women who adopted the role of LHWs. There was a strict set of gender norms and values in place in their households and within the communities. The hallmark being the restrictions placed on women in terms of their mobility and segregation. Overcoming these potential barriers and creating a niche for themselves in the health system was therefore, a formidable challenge.

In the prevailing circumstances, most of the LHWs were denied strategic life choices decisions such as of continuing education or getting married. In view of the gendered division of labour the option or choice of working outside their homes did not arise. The priority was on early girl marriages and the girls did not have a say in this

decision making. Similarly their educational endeavours were brought to a standstill resulting in discontinuation of their education. Although many of the LHWs aspired to pursue a career in teaching, they had to quit education and adopt a role of homemaker due to an early marriage.

In the existing patriarchal setup suddenly, NP provided an opportunity these women never imagined would come in their way. Some households of the LHWs were able to take a strategic life decision in the LHWs favour despite the multifarious gender based barriers such as a defined role of women only as homemakers, seclusion, segregation and restrains on female mobility in the community. In nutshell women were supposed to be confined and protected within their homes therefore; it was a very bold decision on part of the LHWs and their households. Almost all the LHWs prior to joining as health workers were housewives confined to household tasks. Many who joined in the initial cohorts in mid 1990s are still working. Joining as LHWs was therefore, a huge departure from their prior roles and expectations as housewives. The first transition event in life of these women was their decision to join as an LHW. Surprisingly this was primarily their own decision as none of the LHWs included in the study alluded to the duress of their household to opt for this job. In fact there was a significant resistance in the households regarding women's decision to join as health workers. The concurrence of the male head of households was mandatory for joining as a LHW as delineated by the NP policy in view of patriarchal nature of the society.

The strategic decision to become an LHW rather than remain confined to home was one of the major transitions in their lives, more so for the pioneer batches of LHWs, who had no clue about their intended roles or responsibilities. In later cohorts some of the LHWs were already looking for work or were working mainly as teachers prior to becoming a LHW. These women could observe LHWs working in communities. In the initial phases many women trained as LHWs quitted this job to become teachers however, after year 2000 there was a reversal in this trend.

The LHWs have undergone major changes over the years and transformed into bona fide health workers in their communities. The change in women as a result of their

experiences after becoming an LHW was evident in their narratives. The LHWs reported a change over time although the degree of change varied from individual to individual. They often alluded to a transformative change in themselves over time. However, a diversity of experiences was evident between the LHWs as illustrated in the four narratives presented earlier in the chapter. The variations amongst the LHWs can be attributed to their personal attributes, surrounding context within which the LHWs work and socialise. These factors ultimately also contribute in development of their identity as health workers.

There were differences in the socialisation process of various LHWs in terms of their education, financial needs and level of difficulties in work practice i.e. need of chaperoning and degree of involvement in their work. These attributes also played a role in their skills development and further transformation as health workers. There were those who joined and exhibited profound changes while others changed to a lesser extent. This difference is also reflected in the difference in their life trajectories of LHWs. With the passage of time, this cadre has evolved into a non-homogenous group. As illustrated by their life histories, there is no typical or stereotype LHW who represents her entire cadre.

The main impetus and motivation for women moving from hearth to health centre was primarily their financial need, which was explicitly expressed by most of the LHWs. The term “Majboori” i.e. financial need was cited by the LHWs as a major reason for becoming a LHW. There were other explanations also such as *Shauk* (desire to do something) and *Jazba* (enthusiasm) and *Khidmat* (desire to serve) but the overriding factor still remained their financial needs. This was being the foremost reason behind the health workers family’s decision to allow them to join as LHWs. Their families even decided against the prevailing norms to allow the women to join as LHWs because of their financial constraints. Some LHWs however, also developed a sense of service, enthusiasm and interest gradually overtime as shown below (Fig. 4.2). Although the needs of LHWs have also changed, these still persist, albeit in a different manner and most of the LHWs remained in their job and did not quit because of the financial implications.

**Figure 4.2 Reasons to join as LHWs**



The next chapter details an overview of historical aspects of NP especially the evolution of the NP, the training procedure of the LHWs and changes in the health system especially in the health centres subsequent to introduction of LHWs.



# **Chapter V**

## **Historical context and perspectives**

### **5.1 Introduction**

In Pakistan, LHWs the new cadre of female health workers was introduced in 1994. The primary objective of NP was to increase women's access to health services, especially in the rural areas. It was envisioned the LHWs would realize this by providing services at the door steps of their communities. In its formative stages, simultaneously the triad of programme organisation, LHW recruitment and training was given great attention. A brief historical overview of the aforesaid triad is presented in this chapter. The NP was a country wide innovation in the district health system which was nested within the public sector PHC system which mainly catered for the health needs of rural areas and the urban poor.

In the first section, I look at introduction of NP in the district health system as a new PHC initiative. The perspectives and expectations of the health managers regarding NP at its inception are explored. Initially, the foremost challenge was recruitment of women willing to serve as health workers. The influence of patriarchy and the consequent gendered context created difficulties during the selection and recruitment process. The defining role of men in the households during recruiting of potential LHWs in the incipient phase is explored.

In the second section an important aspect of the NP i.e. training component is described. This component was developed and strengthened right at the start of NP. As the training infrastructure did not exist within the district health system, a national capacity building strategy for the NP was developed and implemented. Most of the training activities including the Masters Trainers and LHWs were conducted in a cascading manner from national to district level. The key features of the training and its implementation are also detailed in this section.

The third section pertains to the organisational changes that took place in the district after the introduction of LHWs. The major change in this respect was creation of a new supervisory support mechanism: the Lady Health Supervisor (LHS). This new cadre of women was introduced for close supervision and support of the LHWs in their field activities. Within this section, I will also highlight and examine the ambiguities these organizational changes brought about in the district health system amongst various health workers, especially in relation to the integration of LHWs in health centres. The chapter concludes by summarising and explaining the salient findings.

## **5.2 LHWs as new players in the health system**

The NP was initiated in 1995 in the district with the introduction of a new cadre of female health workers, i.e. the LHWs. The main role of the LHWs was provision of Family Planning and PHC services in their own communities. The district health team was facilitated to plan and prepare the future activities of NP in the district. Doctors, medical assistants and LHVs were trained to introduce this upcoming novel initiative in the district health system. One experienced doctor reminisced about how introducing the LHWs at that juncture augured well for much needed preventive services in their communities under the ambit of this new PHC initiative.

*When I attended the first training, I became aware of the NP. We were apprised about the forthcoming NP and the expected activities of LHWs. At that point what I gathered was that the LHW would serve as a bridge between the community and our health centre. Training would enable LHWs to inform us about health problems in their communities and to communicate health advice to the households. Theoretically, I welcomed this initiative from a preventive perspective, as earlier on, all programmes were biased towards the curative care and a “preventive workforce” was therefore direly needed.*

*(AZ, District Manager)*

In the beginning, many of the staff working in the health centres was uncertain about, what to expect from the NP and especially from this new cadre of health workers. The health centres were mainly hubs of curative services and they have never come across

the concept of community health workers. Still, at the launch of the NP, those involved during the formative stages were enthusiastic about implementing the programme.

*As it was a new programme, initially we had no clue about its pros and cons. This programme was started with much zeal and fervour. We were excited, enthusiastic about being part of a new development and looking forward to the introduction of community based female health workers. We considered this as an excellent initiative because of its focus on the provision of basic health services at people's doorsteps. At that time, we were very hopeful of its success and fully participated in the programme activities to make it successful.*

*(JA, Medical Assistant)*

The first major challenge faced by health staff working in health centres was the task of recruiting LHWs. This essential undertaking was devolved to the health centres, bypassing the existing hierarchal bureaucratic processes of the district health system, wherein the health centres were usually excluded. The search for eligible women willing to join the NP as future LHWs turned out to be an onerous task, however, health centre staff's involvement and responsibility in this task enhanced their sense of ownership of the NP. As discussed later in this chapter, the district health managers had to face and overcome major gender-based challenges during the recruitment process.

On one hand, looking for prospective health workers turned out to be like looking for a needle in a haystack; while on the other many of the interested women did not fulfil the minimum eligibility criteria and were thus not considered suitable for recruitment as LHWs. The health centre staff endured a great deal of pressure from influential people around them to recommend and recruit such candidates as health workers. The health managers' narratives, however, suggest that they strictly adhered to the standardized procedures and NP recruitment policies, which ensured the district's ownership of the programme despite the difficulties.

*The recruitment criteria were quite explicit including education, residence and marital status of potential candidates; still we had to sustain a lot of political*

*and bureaucratic pressures. Implementing the selection criteria was challenging, but we followed the procedures that had been put in place.*

*(ND, District Manager)*

Recruitment did not turn out to be a one-time activity, however, as all the slots for LHWs were not filled in one go and LHWs were recruited in phases or cohorts. Some vacancies of the LHWs in the district remained unoccupied or fell vacant by virtue of dropout or the transfer of trained LHWs to other areas. The recruitment of LHWs was on the recommendation of a notified selection committee, constituted at the health centre level. All efforts were made to streamline a transparent selection process throughout shunning any nepotism. Members from the community were seldom involved in the LHW selection process, except for one notable from each concerned union council. The health centre staff conducted a screening test to evaluate a candidate's reading and writing skills prior to recruitment. The educational attainment was nonetheless one of the main criteria for selecting LHWs.

*The educational criterion for LHWs was devised and the minimum educational level was middle standard, i.e. eight years of schooling, but if we got a better educated one... There were places where we preferred the intermediate women over the middle standard ones, but at others we preferred less educated women. The girls with higher education used to obtain training initially, but quit the job of LHW as soon as they got hold of a better paying job, e.g. teaching.*

*(SM, National Program Manager)*

The selection committees gave due consideration to the educational status, however, at times other factors, like suitability and employment continuity, were important. Thus in the end the decision was based on some kind of trade-off.

### **5.3 Breaking the mould: The search for female health workers**

In the formative period of the NP, the district health staff faced many challenges. The initiative was a new one; therefore this was their first experience of the kind. This programme was launched with high expectations by the staff of the local health centres, particularly since the latter had negligible links with their communities at this juncture. When the recruitment of LHWs commenced in 1995, there were many apprehensions and difficulties, foreseen and unforeseen, encountered in the

communities. The NP's first and the foremost challenge was finding and recruiting women willing to work as health workers despite the deep-rooted prevailing gender norms. The NP had developed national guidelines and standard operating procedures for the recruitment of LHWs in a national consultative process. This was an attempt to implement uniform standards across the country. Although those involved in planning the NP anticipated difficulties and kept these under consideration, in beginning, district health managers still faced major impediments to finding women willing to brook gender conventions in their social environment to become health workers.

*We faced a lot of difficulties in finding potential candidates because of social and religious restrictions in the rural surroundings. In those days, home visiting by women as a job was considered unimaginable in these communities. We faced immense difficulties in this regard. Originally, the educational criteria planned for LHWs was Matric, but anticipating that it would be hard to find such women, it was lowered to middle standard. Hence, middle-pass women able to read, write basic Urdu, and able to communicate were allowed to apply for recruitment as LHWs. We took into consideration age, marital status and local residence of women during recruitment. Those with experience of previous community work were given preference. We were looking for LHWs based on these criteria and at that time it seemed an uphill task.*

*(FT, National Program Manager)*

Since the health staff involved in implementing the NP was aware of women's position in their communities, they considered it a major obstacle in the initial recruitment efforts. The communities were reflection of the patriarchal culture and men and women were designated to different domains. The sexual division of labour, segregation and seclusion of women within purdah confined women to their homes as a norm. Therefore, there was a hesitation on part of the women's families to allow women to leave their homes and venture outside as health workers. The overall social environment also deterred women from becoming LHWs since the work expected of them contravened existing gender norms. The act of leaving one's home and conducting door-to-door visits for work was considered taboo for women and thus, in beginning, this was almost unthinkable. They were worried how women would conduct household visits within the existing social milieu, as visiting others' homes for work was frowned upon and carried a negative connotation. In the case of women, this type of activity was mostly confined to female menial workers, gypsy street

peddlers or beggars, and thus not seen as culturally appropriate or acceptable for most people.

The NP aimed to provide health services at each community's doorstep; therefore, local women's unwillingness to conduct household visits posed a dilemma. These visits were the hallmark of the new initiative and thus vital for the NP's implementation. Therefore, at that point in time, all the major stakeholders were seriously concerned about the future of the NP before it had even started.

*The identification of potential LHWs at that time was a challenge, as we could not find women willing to become health workers. The women did not venture out of their homes. So we were able to locate them with great difficulty.*

*(SM, National Program Manager)*

An LHV who was helping to identify potential candidates for recruitment as LHWs experienced similar difficulties in the field regarding this task. As she said:

*The main problem was to get the women out of their homes. Convincing women to come out of their homes to work with us was proving very difficult. In the beginning, visiting door to door seemed very difficult to them as this was considered an insult. People could not imagine their women would visit door to door.*

*(BS, Lady Health Visitor)*

The NP was a top-down initiative expecting women living at home to come forward and contribute to improving the health of women and children in their communities. The communities were scarcely involved however, in light of the strong political commitment and pressure on all those involved, concerted efforts were undertaken for recruitment of LHWs. A proactive approach was adopted in which the district health staff visited communities to convince them about the value of the LHW programme and to cajole potential women to join the NP. As we have seen, women in the communities with requisite qualifications were not willing, initially, to apply for the LHW vacancies. Prior to this initiative, health centre staff was more or less confined to working within the precincts of their healthcare facilities, this being another big impediment.

At the outset, district health managers and health centre staff were very apprehensive. There was a growing concern that, if women did not venture out into the field, the NP would fail. Subsequently, there was a breakthrough when some women did decide to join, mostly as a result of the proactive persuasion of health department staff in the communities. Contrary to initial fears, some women did ultimately turn up for recruitment, thereby overcoming the prevailing gender barriers. Their numbers were not large to cover the entire district, but adequate enough to launch the training of the first cohort of LHWs in 1995.

*In the beginning, there were a lot of apprehensions. People thought it was not safe to send womenfolk to others' homes. It (the NP) would be a failure as the whole idea of home visits is against the norms of our society. These uncertainties gradually died out, and the programme proved to be a success".*

*(ND, District Manager)*

The recruitment of female health workers was a challenging first step towards launching LHWs still there were others challenges to surmount.

#### **5.4 Paving the way: Men as household gatekeepers**

The women who could potentially be recruited as LHWs mostly lived in close-knit households surrounded by their family members. The nature of the relationship between these women and their families influenced the way they subsequently worked outside their homes as LHWs. The gender power relations at the micro, meso and macro levels i.e. household, community and policy levels followed the gender norms of patriarchy. The segregation and seclusion of women coupled with limited mobility outside their homes was prevalent. In the prevailing setup within communities, women's movements were monitored by gatekeepers i.e. guardians including their husbands, fathers, brothers, mothers and mothers-in-law. The most important among all the gatekeepers was the male head of the household; in the case of a married LHW, this was usually her husband. In the LHWs' narratives, the circles of influence considered as gatekeepers included members of both the immediate and extended family.

Since its beginning, the NP did not challenge the prevalent gender norms and adhered to the community's normative thinking in many respects. When the NP was introduced, it was a proxy of gender differentials, the main focus of which was on improving women's health through a female health cadre, i.e. following the norms of society. The NP was devised in such a way that although the LHWs were envisaged as agents of change in their communities while largely remaining within the norms of the existing patriarchal structures. If a woman was taking a strategic decision to join the NP as an LHW, receiving permission from the head of her household (traditionally, the husband in the case of a married woman or father in the case of an unmarried one) was a mandatory prerequisite. When women applied for the slot of LHWs, they were required to submit a permission affidavit from their head of household, without which their application would be turned down. Many women who were otherwise eligible could not join as they were not granted permission by the male heads of their families. Therefore, right in the beginning, the gatekeeping role of a woman's husband and the other men in her household was acknowledged and legitimized by the NP. Women were rarely allowed to act as guardians for potential LHWs. This procedure has been in practice from the induction of the first LHWs in 1994 to the induction of most recent cohort in 2009. The recruitment process entailed an assurance by the male head of household that his family would not stop the LHW from pursuing her job in the community.

*When we accepted an application from a woman for an LHW, she had to submit a permission letter from the head of the household. In case of married women, from the husband, and in case of unmarried, divorcees or widows, the father's or brother's permission was required. In the initial phases, this criterion was strictly adhered to, while in the later phases, written proof of this permission was not required. When their homes were visited for verification of their residence, their family members gave verbal permission, but this was not without problem, as family members expressed reservations about the LHW's assigned tasks when the latter commenced their fieldwork.*

*(JA, Medical Assistant)*



To avoid such a scenario, LHWs were informed of their duties at the time of selection and only recruited if they were willing to undertake those tasks with the permission of the male guardian.

*An LHW with restrictions cannot work. Once the people in the household give permission, they cannot put up any kind of restrictions when she starts work. The LHWs are already informed during their selection and training that they have to work in the field. At that time, the household members are willing and give permission. It is only afterwards, when LHWs have been recruited, that they make excuses!*

*(SH, LHW Supervisor)*

Because a written undertaking had been submitted at the outset, family members were not expected to show reservations at a later stage. This also served as a safeguard for the district staff so they were not held responsible in cases of default. Many LHWs felt that imposing restrictions on them by their family members at the start of fieldwork was unjustified. In many cases, however, a complete reversal was reported, and husbands who had originally granted permission changed their minds after a period of time. The most frequently cited reason was their disapproval of the concept of household visits in the community because these went against their family honour. Many LHWs quit their jobs, especially in the early cohorts, as this practice was not acceptable to them or their households since it conflicted with traditional gender norms. Many LHWs like Khalida were apprehensive about their future since their continuation of work was dependent upon their husband's permission, which could be withdrawn at any time. In Khalida's case, her husband was not happy that she was employed as an LHW and especially opposed her household visits. For years, she feared he would rescind his permission.

Although the husband was the key gatekeeper, others in the LHW's family also played a role in her work. This role could either be negative (opposition) or positive (enabling). The South Asian concept of family includes not only the couple and their children, but also members of the extended family. Many women did not join the NP as LHWs as they faced opposition from within their families, especially from male family members. Those showing reservations included their fathers, brothers and other close relatives. Brothers, in particular, often did not want their sisters to work as

paid job was against their family honour and according to the gendered division of labour men were supposed to be the breadwinners while women stayed at home. However, according to cultural norms, a woman's husband can overrule her brothers' decision, and the LHWs successfully negotiated this to their advantage in most cases. But even adult brothers often posed difficulties when a woman decided to become an LHW, even for those who were married and living independently with their husbands. In a few cases, almost every single male member of an LHW's family opposed her joining due to their family honour, but her husband granted his permission.

*The men in the family did not agree, especially my brothers and father. My brother said, "I will shoot you if I hear any gossip of men outside the family". My brother and my mother-in-law said, "Our family will starve to death, but will never allow you to work like this".*

*(RS, 35, LHW rural, 2009)*

The influence of *biradari* (clan) in creating an opposition to the households was evident in many cases. One married LHW was living with her in-laws, who had no objection to her becoming an LHW, while her own father opposed her decision because he was embarrassed that his daughter was working for money in opposition to his clan's norm regarding this matter. He regarded this as a very shameful act under his clan's gender-defined roles.

*My father opposed ... the thing is there was ignorance and illiteracy throughout my family and [he was afraid] biradari [clan] people would object that is it why he was against my joining as LHW.*

*(MR, 28, LHW rural, 2009)*

The influence of those around them was not always negative, and LHWs often managed to use this to their advantage by harnessing support throughout the family network. In one instance, for example, an LHW's extended family members were able to convince her husband to let her continue her job and to alleviate his anxiety about the nature of the job, which he considered to be gender inappropriate.

*My husband said I should quit as household and BHU visits were undesirable to him. I refused to quit as I had shauk [passion and eagerness to work] and wanted to do this work. As we could not agree, I asked a few relatives to*

*mediate and they accepted my argument. In the end they were able to convince my husband.*

*(SP, 38, LHW rural, 1999)*

The opposition to women working as LHWs was not only confined to brothers; brothers-in-law reportedly displayed similar values. They considered the LHW's work, especially the household visits, to be disgraceful for their shared family honour. Therefore, the LHWs considered support at the household level to be vital for the continuation of their jobs. The facilitation of male family members was considered as important as their opposition. One LHS considered this enabling support of men in the household a crucial step for women to work as LHWs.

*One main thing is that without the support of men, women cannot leave their homes. The men in the households of the LHWs mostly support them and there are fewer problems since LHWs came out to work with the permission and help of their husbands.*

*(SH, LHW Supervisor)*

This facilitation by household members (husbands, sisters in law, etc.) was acknowledged by the LHWs and accepted as being a pivotal factor in their joining and continuing this work. In many cases, the LHW's mother-in-law was the one to provide support, sometimes even opposing her own son, who was not willing to let his wife work. Support from the mother-in-law was a lifeline for an LHW whose husband was away for seven years. As she said:

*My husband is now working and earning in the Middle East and wants me to quit, but my mother-in-law being the decision-maker does not agree with him. She is of the view that I have worked very hard over the years and now I should not quit my job.*

*(RY, 37, LHW peri-rural, 1998)*

The role of the various stakeholders around LHWs was important in facilitating their work by overcoming the gender barriers being faced by the LHWs to enable them to join and continue working as health workers. The power was vested in men who decided on strategic choices on behalf of their womenfolk and this was further strengthened by the NP policies to gain permission from the male head of household to join as an LHW.

## **5.5 Health workers' training needs and modalities**

The NP started as a very dynamic initiative with plenty of support and facilitation from the higher tiers of health management. In 1994, when the NP started, training in the public health sector was not institutionalised, with very little training being conducted at the district level. Short-term training was occasionally offered in collaboration with WHO, UNICEF and other similar organisations, usually as a component of specific time-bound projects, such as those related to immunisation, skilled birth attendance and communicable disease control. Mainly cadres of doctors, lady health visitors, vaccinators, traditional birth attendants and some outreach health workers were trained.

The lack of teaching and training capacity was recognized right in the beginning and addressed as a priority. Concerted efforts were made to institutionalise training activities at the federal, provincial and district levels, which included devising and implementing a national capacity building strategy for the NP. Standardised training was developed, planned and offered across the country. In the beginning, a top-down approach was adopted for operationalising these training activities. A uniform curriculum, standard methodology and proactive supervision at all levels were planned to ensure the quality of training. Separate training manuals for different tiers of trainers were also developed. All trainers were compensated for their additional NP-related responsibilities with an incentive amounting to twenty percent of their salaries as an allowance.

The health centres where the training of LHWs was to be conducted were designated as "Training Centres." Training was entrusted to a team comprising a minimum of three health care professionals, a doctor, a Lady Health Visitor (LHV) and a male Medical Assistant (MA). These professionals, trained as Master Trainer or Trainers, were also involved in the selection of LHWs from their own area. During initial phase of LHW training, all fourteen health centres (BHUs and RHCs) in the study district were designated as training centres. The LHWs selected from each union council

were attached to and trained in their respective training centre. However, over time, the number of training centres was reduced because most of the sanctioned LHW posts had since been filled, which meant that fewer LHWs were being trained to fill vacant places. In later phases, LHWs were also trained in training centres that were not located in their own health centres. Therefore, later LHWs were being trained in a cohort drawn from different health centres.

The training was based on a prescribed national guideline, and a standard curriculum was used throughout the country. Its duration and schedule were uniform regardless of where a LHW was trained. Training of health workers in their mandatory classroom teaching was based on a training manual developed in Urdu. This was highly regarded by the trainers interviewed in this study as it enabled them to train all LHWs, including those with less education.

*The module was comprehensive covering many subjects and areas. The numbers of LHWs in a class were limited; making it easier to teach. The contents were in a simple language therefore, the girls understood the manual. Some girls possessed the minimum educational requirement i.e. middle and sometimes they had problems in following the training, but the majority were intelligent and encountered few difficulties; the ones who had Matric or higher qualification understood the curriculum well.*

*(ZU, District Manager)*

All training centres followed a uniform schedule of six days a week. Each centre maintained an exclusive class room for LHW training, which was funded by the NP. The initial training period of three months was based on a prescribed training manual and included classroom teaching, home assignments and both didactic and practical exercises. During this time, participants were introduced to field settings since they were supposed to register households in their catchment areas. Following this initial three months, LHWs worked in the field, but returned to the classroom for a week every month, for the next 12 months.

Once the fifteen months of mandatory training was complete, LHWs were required to visit their respective healthcare facility once a month. This monthly visit was usually scheduled in the first week of month. On this occasion, LHWs submitted their reports,

planned field visits, received feedback and replenished essential supplies. This was also an opportunity to liaise with the outreach staff like vaccinators for scheduled activities in their area.

## **5.6 Training the LHWs**

Along with recruitment of LHWs, another key step towards implementing the NP was the development of “Master Trainers”. A senior health manager who participated in the very first training of these individuals recollects that this was conducted by the authors of the national LHW training manual. The trainers introduced training methodologies, including how the manual should be used to teach LHWs. The first master trainers were all doctors and used to English as the language of instruction. The training of LHWs, on the other hand, was supposed to be in Urdu, which initially seemed rather challenging. Therefore, without a precedent of training, hosting a new program in the district was a learning curve for everyone involved. The main focus of the health centres was on curative services; this programme of training, however, renewed the staff’s interest in PHC and providing preventive services. In past, they were not involved in any training activities; after introduction of the NP, however, this became a regular feature of their work for many years.

Teaching novice women was a unique experience for the trainers, more so because of the wide knowledge gap between the two groups. In addition, there were marked socioeconomic differences between the training cadres and trainee LHWs. A district health manager recollects his views at the launch of LHW training.

*I had been working in the rural areas for a long time and my own background is also rural, so I had some idea about the “calibre” of the potential LHWs. I was glad to train the LHWs so they would have a certain degree of knowledge and gain experience in the field; expecting all of this to enhance their learning.*

*(AZ, District Manager)*

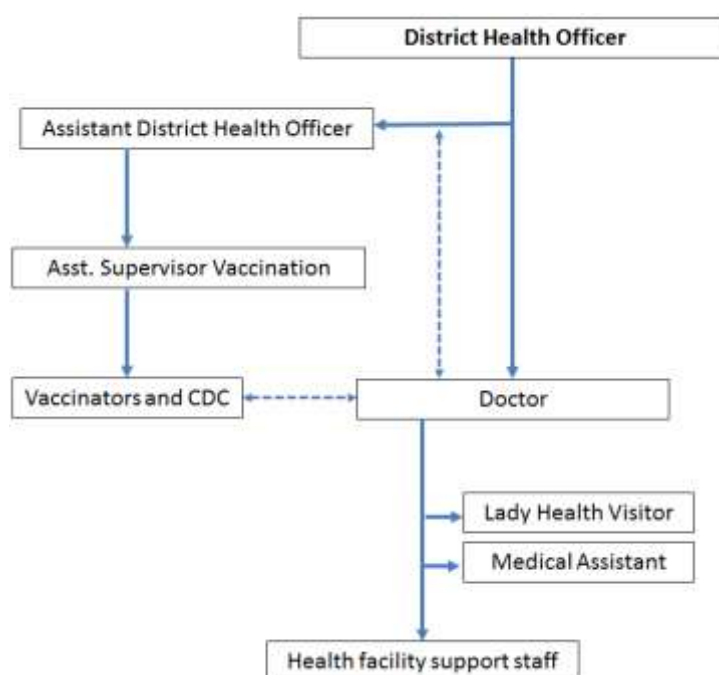
The planning and implementation of training activities for the LHWs was a big challenge particularly at the start of the NP. As many cohorts of LHWs were trained

over the years the training capacity of the district health team and training infrastructure improved with time.

## 5.7 Introduction of the NP: The organisational challenges

At the inception of the NP, the healthcare teams at the health centres were comprised of a doctor (male or female), an LHV, a male medical assistant and some support staff. The LHVs were responsible for providing maternal and child health services, under supervision of the doctor or male medical assistant. Although the vaccinators and communicable disease control staff working in the field were detailed to the health centres, they came directly under the district health officer and the assistant district health officer's administrative control. The organizational structure of the district in 1994 prior to introduction of the NP is shown below in Fig. 5.1.

**Figure 5.1 Organization of the District Health System**



The male doctors were preferably divested with administrative authority in the health centres by the health department. In their absence, the LHVs were administratively subordinate to the male medical assistants, despite their being a little higher in the

organizational hierarchy. This organisational gender differential stemmed from the fact that the organizational norms were a reflection of prevailing gender norms, i.e. of different expectations of men and women in the workplace. When NP was introduced, the health centre in-charge was also supposed to oversee all of the new programme's activities there. By virtue of being female, however, the LHVs were especially assigned to LHW-related tasks, such as training, monitoring and supervising them. The LHVs were expected to play a major role in the NP based on their gender.

*As an LHV, I was made in-charge and the NP managers who visited my health centre told me that the male staff members must not be involved in the NP. The male staff members were only given the training sections on child health and health management information systems as trainers.*

*(NJ, LHV)*

The NP was very explicit about the gender roles of male staff. The directives were quite clear at the policy level that men should have minimal contact with the LHWs, but there were still some issues at the health centre level.

*The NP plan does not favour males overseeing the LHWs. Only a LHV, female nurse or any female staff member like a women doctor can interact with LHW. This was a very strict order; however, if there is a case of tuberculosis or another such issue, contact with a male member of staff was allowed. The main interactions allowed in the programs are mainly on the female side.*

*(FT, National Program Manager)*

While the medical assistants viewed their involvement in a positive manner, the LHVs were sceptical of the male health centre staff and what they saw as their adverse effects.

*I worked as a trainer in a few centres during the formative phase. I experienced the involvement of men in the NP initially. However, later on, we were told, LHVs and LHSs will supervise and look after the LHWs. Only if they require support we will be involved with the LHWs.*

*(JA, Medical Assistant)*

*Some LHWs quit due to the men's attitude, as in beginning the male staff used to go to their homes and even visited the community and the parents and in-laws of the LHWs, who did not like this and objected.*



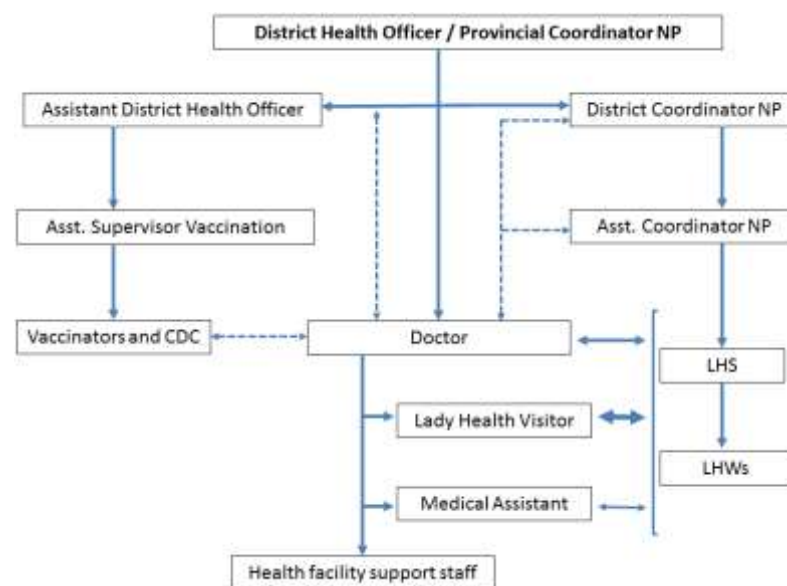
The health centres were supposed to compile a composite monthly report for the NP, on a prescribed form, and send it to the district coordinator of the NP. However, many such tasks were already being carried out by the men who were in charge of the centres. Thus, at this level, there was some overlapping of responsibilities, which created conflict amongst the staff regarding NP related activities. This also led to administrative ambiguities, as described by an experienced male doctor working in a RHC where a female doctor was also posted.

*In principle, I used to be in charge of LHWs in my previous posting. However, no such notification existed. This condition resulted in problems; either no one was in charge or it was implicit that the most senior doctor would be in charge. The same position continues here without any proper notification.*

(KI, Medical Officer, RHC)

To oversee LHWs in their field activities, another female staff member, i.e. the Lady Health Worker Supervisor (LHS), was introduced by the NP. The LHS's main task of supportive supervision was to be accomplished through a liaison between the LHWs, health centres and the community. Before her deployment in the field, the LHS underwent a year of comprehensive training to learn how to supervise and support LHWs in their fieldwork. The LHV's task as trainer was to enhance and polish the competencies of the LHWs, while the LHS was to support their knowledge and skill building. Within the NP, the institution of the LHS was a strategic initiative to further an elaborate and uniform system for supervising LHWs throughout the country. The organizational setup after the introduction of the NP in the district is depicted below in Fig. 5.2 and includes both cadres of LHWs and LHSs.

**Figure 5.2 Organization of the District Health System after NP introduction**



The issues concerning the demarcation of NP duties at health centres were faced by staff members. An experienced manager shared his views about this longstanding issue. Despite the delineation of responsibility, doubts regarding LHWs in-charge still remained. Interestingly, one explanation given for this state of affairs was linked to the withdrawal of financial incentives for overseeing the LHWs:

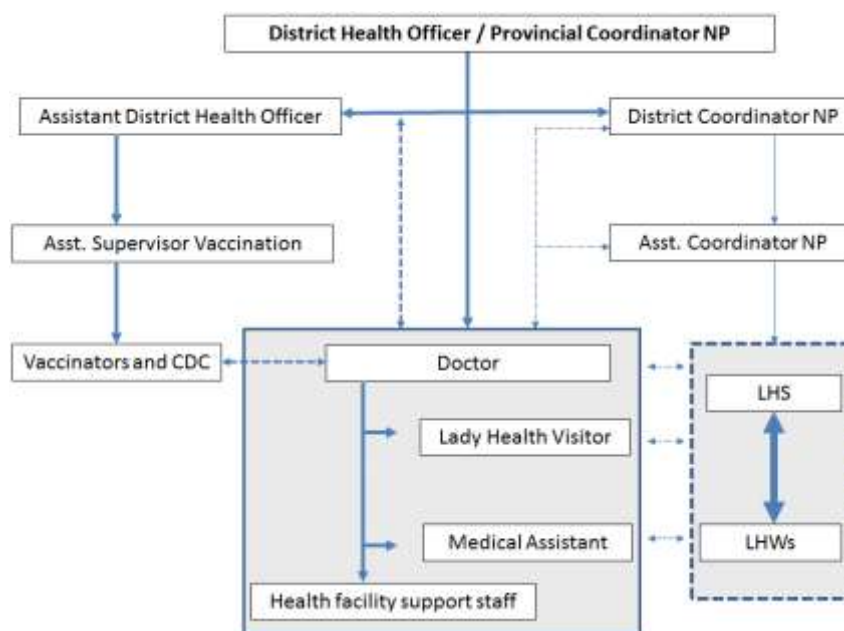
*The health centre in-charge is the person responsible for the LHWs; could be a doctor or medical assistant. If an LHV is there, she deals with the LHWs. The truth is since the 20-percent incentive was taken away, the doctors think they have nothing to do with the LHWs. So, technically speaking, the doctor is in charge, though not in reality!*

*(NG, District Manager)*

The withdrawal of the incentives given to health centre staff at the beginning of the NP drastically reduced their interest in the programme and many disowned the LHWs altogether as a result. This further contributed to shifting LHWs towards their respective LHSs, as the health centre staff increasingly considered the NP as a separate entity and their ownership of its activities diminished. With the passage of time, the ownership of the LHWs changed hands due to the lack of incentives and

other organizational issues. Gradually, the LHWs moved away from the health centre, while the NP was still grounded in the health centres within the district health system. The issue will be discussed further in chapter 8. These changes and how they affected the LHWs on ground is depicted in Fig. 5.3

**Figure 5.3 Organizational relationships of the NP in the District Health System**



The integration of the LHWs belonging to the NP at the health centre has been an issue. Although it had been more than two decades but still there was at times a dichotomy. This impacted on the socialization of the LHWs effecting their work practices and identity.

## 5.8 Conclusion

The NP was launched as a top down initiative with very high level of political commitment of Prime Minister and persistent support at the policy level. The anticipated commencement of the NP and introduction of the LHWs created ripples in the district health system. The health centres' staff working at the district level foresaw this as an opportunity to develop and strengthen their links with their

communities. This was a novel undertaking envisaged to reduce the gaps between communities and health centres and thus improve the PHC services. The challenges faced in recruiting and deploying female health workers were twofold. Firstly there were concerns related to the sociocultural context of the communities which directly impinged on the vital issue of recruiting the LHWs. Secondly the systemic issues of lack of training infrastructure and integration of LHWs were also a cause of concern. This second issue was within the purview of the NP and due to the high policy level commitment and interest the training capacity was developed at a rapid pace. A national curriculum was developed and used in a uniform manner in trainings conducted throughout the country including the study district. The success of the national capacity building strategy can be attributed to the political will and is an illustrative example of when there is a will there is a way.

The overall societal structure of the communities where prospective LHWs lived was patriarchal with well-defined role of men and women. Expecting the communities to break gender norms out rightly was not based on ground realities. The very idea of women pursuing paid work in households where men are supposed to be breadwinners was alien and very contentious. There were strict proscriptions on women mobility and interaction with unrelated households. These gender norms were just opposite to NP requirements i.e. moving around while pursuing work outside their homes and moreover, visit all households in their catchment area. The gendered nature of the social relations at the family and community level was in sharp contrast with the NP intentions.

The NP introduced the LHWs without any concomitant micro, meso or macro structural change to reduce gender inequalities. Therefore, the recruitment of women proved to be herculean task. In the end due to the strenuous and proactive efforts of those involved at various levels, women in sufficient numbers joined NP enabling initiation of the training of LHWs. As discussed in the previous chapter Majboori or the financial need was main reason behind their opting for this work. Nonetheless the NP was successful in recruiting LHWs despite all odds and this was an achievement. The men in LHWs' families were accepted as gatekeepers and therefore, NP followed the community's gender norms and power differentials in this respect.

The introduction of the NP required changes in the organizational structure of the health department. The LHS was introduced to support LHWs in their communities. This also added ambiguity regarding who actually was LHW's superior. Over time, the health centre staff's interest in and affiliation with LHWs diminished, the result of which was that most LHWs felt closer to their LHSs. One reason for progressive lack of interest in NP activities was the withdrawal of monetary incentives for health staff. LHWs' relationships and positioning in the health centres also affected the LHWs, which caused the LHWs to feel, at times, that they were not part of the mainstream health department. This, in turn, led to feelings of neglect and exclusion. The optimism of close links of health centres with the community through community based health workers and concomitant improvement in PHC in the district health system leaves a lot to desire. The lack of integration of LHWs within the health centres and overall district health system was seemingly problematic at the ground level. This might be a reflection of a weak health system and dwindling political will. Interestingly, in light of the gendered organizational setting within the health centres, the LHWs turned out to be a relatively segregated workforce within these institutions.

The next chapter will present the socialisation process of the LHWs. The barriers and facilitators of socialisation will also be discussed.

# Chapter VI

## **Professional socialization: Pathway to a transformative change**

### **6.1 Introduction**

The LHWs were introduced to enhance links between community and the district health system. When the LHWs joined as health workers almost all of them were housewives. These women were expected to conduct regular household visits in their communities, in order to provide maternal and child healthcare services to families at their doorsteps. Before commencing work in their communities, all LHWs underwent an initial phase of training. As they embarked on their journey, LHWs faced many challenges. Their training and subsequent field work contributed in their socialisation as health workers.

The first section of this chapter describes the training experiences of the LHWs. Coming face to face with the health centres for the first time during their recruitment process and mandatory training, their development as health workers commenced with their training. The LHWs and the trainers' experiences regarding the trainings of LHWs are presented in this section.

In the second section, I will discuss some of the difficulties LHWs encountered when they commenced their work in communities. The early experiences of LHWs' entry into the field and the difficulties encountered due to the prevailing gender norms in their specific context are detailed.

The third section encompasses the LHWs' interaction with important contextual stakeholders in the community i.e. Mothers-in-law, Dais and men residing in their communities. The sociocultural barriers hindering the LHWs from making inroads into communities through male health committees will also be described.

In the fifth section, I will highlight the relationships between the LHWs' and the transformative changes LHWs underwent; highlighting the values they learned, during the course of their work. The last section sums up the results and conclusions.

## **6.2 Training of the LHWs: Experiences and concerns around learning**

Being new to the place, the LHWs were quite apprehensive during their first exposure to the health centre. Hardly any of them had visited the health centre before, except for their LHW recruitment process. They were mostly housewives confined to their homes, following the prevailing gender norms of their communities living in segregation with proscriptions on their mobility. The social interaction of these women with unrelated men was minimal. This was the manner in which they had been socialised and they were well accustomed to in their family setup.

The formal socialisation of the LHWs as health workers however, commenced with their training at the health centres. This was their first interaction with outside world in their new role as health workers. Although they had attended school, in most cases, it had been quite a while. At the outset, they were briefed by the trainers in the health centre about the NP and their expected future role and responsibilities. When the pioneer batch was trained, only their own cohort was around in the training centres. In later years, many cohorts of LHWs were already working, so the training environment had changed and there was some interaction with peers therefore, the LHWs felt less intimidated on arrival. The apprehensions Mehtab experienced when she first arrived for training were very typical of what most new LHWs felt.

*There was a kind of fear, what kind of questions will they ask? I do not know English. If there is reading and writing, what will I do?*

*(MB, 52, LHW rural, 1996)*

Teaching novice women was a unique experience for the trainers, more so because of the wide knowledge gap between the newly recruited LHWs and trainers, who were experienced health care staff. In addition, there were marked gender and socioeconomic differences between the training cadres and trainee LHWs which impinged in future on their socialisation process. A district health manager recollects his views at the launch of LHW training.

*The LHWs had no prior knowledge about health, and a comprehensive technical training was being offered to them. To achieve our objectives, the reproductive system, childbirth, child health, vaccinations and other maternal and child health-related issues, including family planning, were taught. Training a lay, totally raw person with little educational background was a difficult task and its accomplishment was an endeavour requiring a lot of effort.*

*(ND, District Manager)*

The challenges were not only confined to the trainers. After receiving the training syllabus at the training induction, most LHWs themselves were wary of what lay in store for them.

*I was a little afraid. This is such a big book [training manual] how can I read and memorise this? Initially I was mentally upset, however, gradually I decided to work hard and it paid off; I performed well in my training and my standing was first throughout my training. In this RHC, we were evaluated through tests from beginning till the end of course, and I always obtained good marks. The [training] experience was very nice, contrary to my earlier expectations.*

*(RK, 40, LHW peri-urban, 2003)*

Training LHWs about health issues was not a very straightforward process. Given the low educational level of the women being trained, the trainers faced challenges conducting traditional classroom teaching.

*Great difficulties were encountered, lots of them, but we had been advised to be extremely lenient and tolerant! Still it was difficult, as they were not familiar with the terms; this required a lot of repetition and revision.*

*(FT, National Program Manager)*

Most of the LHWs had quit education decades before joining the NP as health workers and were mostly confined to their homes. Many LHWs faced difficulties keeping pace with training but gradually were able to come to terms with what was being taught. In this phase, the educational status of the LHWs also mattered as the more educated ones were better able to follow the training.



*We could categorise LHWs based on their attributes, the younger they were, the more able they were to understand what they were told, in contrast to the older ones, who possessed middle education, and that, too, pursued years back.*

*(NG, District Manager)*

In later phases, some women were teaching in private schools before becoming LHWs and they faced fewer difficulties during training. However, those coming directly from household chores found it very difficult to follow what was being taught and had to work really hard.

*I attended my training with difficulty, alternating between bringing my young child to the centre and leaving him at home with my father. I did not understand the training manual. I had not read a book for years and this was difficult stuff as these were medical things, making it very difficult to understand. Initially I did not understand what was being taught. After about one week I informed my trainer that I regularly read and studied at home, but I was still not been able to understand or remember anything. I want to do continue but what shall I do! She assured me that after one to two weeks I would be able to understand what was being taught and that is actually what happened.*

*(SH, 38, LHW peri-urban, 2009)*

While the LHWs were grappling with their own learning, the trainers, especially those in the initial cohorts, were also confronting difficulties. At the outset, most of them were not well prepared, as a pioneer manager of the NP in the district acknowledged:

*This was a learning experience for us, and we continued to learn throughout the training. In the beginning, this was more or less a hit-or-miss trial learning process. We were [constantly] improving upon the things based on our experiences over time.*

*(MZ, National Programme Manager)*

A trainer in the field shared similar views regarding lessons learned and the gradual improvement of the training being offered:

*The training of the LHWs has been very good. In the beginning when training was conducted, there were a lot of deficiencies; however, with the passage of time, training was being conducted in a better way.*

*(JA, Medical Assistant)*

As most LHWs did not know about the training beforehand, this added to their anxiety. However, in most cases, the initial apprehensions decreased as the LHWs settled down and came to know their roles and responsibilities. The three-month training thus allayed the fears of some of the LHWs. Their concerns were not confined to the contents of training, however; the training environment posed another problem. For many women, it was the need to interact with the health centre staff that worried them. Although the staff in the health centres included both men and women, the environment was mostly male dominated. This was a cause of concern for the LHWs as they were not used to interaction with unrelated men but during training this interaction was unavoidable.

Women in the later cohorts, who had quit their teaching jobs to become LHWs, were anxious about their ability to adjust to this different field.

*I did not have any fears, but I felt there was a difference between teaching and LHWs work. I wondered whether I would be able to adjust myself as a health worker. I had this in my mind; otherwise I did not face any problems.*

*(SF, 45, LHW peri-urban, 2006)*

Most of the LHWs acknowledged and valued the increase in their knowledge during training. The training also enabled them to perform their field tasks; something which they perceived would have been difficult without it.

*Prior to our training, we did not know anything about health! We kept on visiting the BHU for three months, then for another year and we were taught about health care. It was only after this training course that we came to know how to take care of health and our learning is still on going.*

*(TB, 36, LHW rural, 2007)*

One LHW, however, acknowledged that after they began community work, their training sometimes seemed inadequate. She consequently felt additional support was needed from the trainers and consulted them during her subsequent visits.

*In the beginning, we didn't know the value of training, especially in the first three months, but when we visited the field, we realised we should have learnt more! Many questions arose and we used to look for answers in the book and even sometimes inquired from health centre staff. I used to think, maybe we had not learnt the way we should have or the duration of our training was not adequate enough, I don't know. However, I did realise I should have learned more!*

*(PA, 55, LHW peri-urban, 1995)*

The LHSs felt that health workers were equipped with knowledge during their initial training, but considered this insufficient for field work. The LHWs, therefore, needed further support to perform their tasks, which was provided by them in the field setting.

*When they come first, women do not possess a lot of knowledge; however, during training they gain theoretical bookish knowledge. This is not enough for LHWs to venture into the field on their own and therefore, they still need additional support from their Supervisors.*

*(AB, LHW Supervisor)*

The initial three-month training seemed to have a lasting effect on LHWs; even after decades, most still considered the knowledge they gained to be useful. However, some LHWs did admit that, over the years, they had forgotten a lot of what was learnt during their training. Both the trainers and the LHWs belonging to initial phases believed the earlier trainings were better and more beneficial. However, in the later phases, many LHWs showed reservations regarding their classroom training. In the opinion of one LHW, who had quit and subsequently re-joined the NP after a six-year gap in 2009, the standard of training had deteriorated over the years. Despite the numerous challenges faced by LHWs in the first cohorts, the earlier training was considered the best.

*Truly speaking, in the beginning, when a doctor trained the LHWs, they worked very hard, especially in the initial batch. It continued for the next two cohorts, but afterwards the standard of training was not the same.*

*(AB, LHW Supervisor)*

The LHWs' understanding of their curriculum, was considered crucial as this was an indicator of their knowledge and skills. The quality of training gradually deteriorated over time as reflected in the LHWs' acquisition and application of knowledge. Sughra noted:

*We were trained in the 1998 phase and we are the best! We were administered written tests during the training and [that is why] we are still better than the rest. There were variations in the training for different batches. Those who trained before us in 1996 had less education. They lagged behind in their knowledge and knew less. There is another, later batch that is very slack, with a low level of knowledge and understanding of the book.*

*(SU, 41, LHW peri-urban, 1996)*

As far as classroom training was concerned, contrary to the earlier emphasis on refresher courses, there has been a visible slowing down of the whole process. In the last decade, no new batch of the LHWs was trained nor any refreshers conducted. Some LHWs trained in later phases are not even aware of the concept of refresher trainings. However, under the current circumstances, one-day monthly meetings remain the mainstay of continuing training. Some training activities, though, are still being conducted, particularly in reference to special assignments and tasks like polio, bird flu, and when a need emerges.

The age criterion for LHWs during selection was eighteen to forty-five years, and married women were given preference. A few of the LHWs had to cope with pregnancy and child delivery during their initial mandatory training. Women in Pakistan are culturally bound to observe the forty-day postnatal period called *chilla* (retreat). Traditionally, a lot of taboos and cultural norms surround this crucial period, including what a woman can and cannot do, e.g. leave her house. Many women broke this cultural barrier to attend their training. For instance, one LHW recalled that she joined training when her son was only four days old.

*My son was born on the same day that the letter of LHW appointment came. I joined four days later. My son was born after three daughters; therefore, I faced a lot of family opposition. I applied for ten days' leave, but I was informed there is no leave during this training. I attended my training, sometimes leaving my child at home with my father or I brought him to the centre. On the completion of my training, my husband told me to leave this job, as it was the month of May and extremely hot [over 42° C] and it was very difficult to commute. Moreover, I also had to pursue my household chores.*

*(SH, 38, LHW peri-urban, 2009)*

Training was a tough time for many women, especially for those with young infants. The successful completion of this training was mandatory, and defined the future career prospects of the health workers. The LHW trainings were arranged after several years in health centres; the decision to attend or leave this opportunity was consequently a difficult one. Many of these women were already hard pressed for a job and thus decided to participate in the training. One LHW joined the training, but had to leave to give birth; she re-joined her training only after twenty days.

The women cited above defied the prevailing gender norms. This also reflects their need and their desperation to join the NP as LHWs. These women were restrained by their families and shunned by those around them, but still, their *majboori* was such that they decided to begin their training despite these obstacles. They somehow obtained permission from the members of their household. Moreover, these deviant cases were willing to take a big risk while embarking on a new career breaking cultural barriers.

Being full time and regular, the training was considered difficult as LHWs also had to undertake their household chores. These competing priorities in the lives of female health workers posed additional burden on the LHWs. The newly inducted LHWs were mostly lay housewives and transforming them into health workers was a difficult process. Nonetheless, this training was a unique experience both for the LHWs and their trainers. The training of health workers possessing limited education with the expectation that they will serve as extensions of health services in the communities was a challenge for everyone.

The very act of joining as a LHW despite social constraints can be considered the first transitory event in the life course of trainee LHWs. The initial three months classroom training of LHWs at the health centre being the second transitory event and initiation of a formal socialisation process. The LHWs' training was based on a prescribed curriculum which imparted both knowledge and necessary skills to trainees. This training was a novel experience for the LHWs as they were introduced to PHC especially maternal and child health. The LHWs interacted with other LHWs, trainers, and staff at the health centres. This transition was the first step towards becoming health workers.

Once the classroom training was complete the LHWs were expected to commence the household visits in their communities. The interaction of the LHWs with the health centres continued and the training culminated with the successful completion of their fifteen months training. This was another landmark being the fourth transition of the health workers in their role as LHW. The LHWs by now had more than a year's field experience of working in their respective communities. Moreover, they were working in close interaction with the health centre staff. These socialisation opportunities influenced the work practices and development of the identity as health workers. The LHWs faced many difficulties when they embarked on their journey after training in their respective communities which by then they have overcome to a great extent.

### **6.3 Venturing into the field; making inroads into the community**

The initial mandatory training of LHWs was mainly aimed at enhancing the health workers' knowledge. This training was conducted in a classroom-setting in groups. The field activities considered important for the LHWs' forthcoming tasks, such as catchment-area mapping, household visits and community organization, i.e. health committees, were briefly introduced here. Once they completed their classroom training, the LHWs faced serious challenges while conducting household visits in their new role as health workers. These early experiences were vividly recalled by all the LHWs in their narratives even after lapse of many years. Venturing out into their

communities was the biggest obstacle LHWs had confronted, after opting to become health workers and undergoing mandatory class room training.

Regular visits to the households in their communities were the mainstay of the LHWs' responsibilities, and the women needed guidance and support to overcome the difficulties they faced during their initial visits. However, they were expected to carry these visits out on their own, with only negligible support and facilitation forthcoming from their health centres. In the beginning although some of the problems LHWs faced when they started their fieldwork could have been avoided, at that juncture, even trainers did not possess enough experience or expertise to be able to mitigate these issues for LHWs.

Despite being residents of their respective catchment area, most LHWs had never visited most of the households there. A vast majority stated that they had never ventured out of their homes unaccompanied, as was the cultural norm. Women were not encouraged to visit their neighbourhood without a family acquaintance or specific purpose. Their interaction and mobility within their communities was confined to a circle of relatives and some specific neighbouring households. Although more pronounced among unmarried LHWs, the married ones, even if born and raised in the same community, shared a great degree of reluctance to perform household visits.

Another major challenge confronting the pioneer batch of LHWs was how to legitimise their own role as innovative entrants to the health system. Deployed in communities, they were supposed to act as a link between community and health centre. In the beginning, it was difficult for LHWs to explain their mandate, let alone convince the community to cooperate. Many LHWs found explaining their position a struggle, as the individuals they encountered could not comprehend it. This lack of understanding was expressed by LHWs working in both rural and peri-urban areas, and was most poignant in the narratives of the pioneer cohorts. Sughra described the effort it took to explain who they were:

*In the beginning, people asked us who we were and from where we had come, from behind closed doors and without opening them for us [thus making us feel unwelcome]. It took us many months to convince them to let us in and to*

*introduce ourselves. It was a big problem because when we visited nobody talked in a civil manner. They said that they were used to visiting the nearby hospital in case of need and did not want anyone to visit their home.*

*(SU, 41, LHW peri-urban, 1996)*

Many of the LHWs were familiar with their communities to some extent, even before joining the NP; however, accessing households during initial visits still seemed a daunting task to Khalida.

*In the beginning, we could not imagine visiting households in our community. We were very anxious and upset; however, at the end of the three months' training, we were mentally prepared and finally we did actually visit. Initially, when I planned a house visit, I used to hesitate and wondered what would happen, whether the household would welcome me or not! Of course, these types of hurdles existed, but slowly things changed for the better.*

*(KA, 54, LHW rural, 1995)*

LHWs' reluctance to visit households and the households' hesitation to allow the health workers to enter were very real impediments to the LHWs' initial engagement with their communities.

*When, for the first time, we went to the field we dreaded going inside homes. "How I will enter the house and how I will talk with them?" It was like this for quite some time, but now, after talking with people and listening to them, I have developed confidence. In the beginning, they did not value our advice. At that time, we also used to hesitate before giving advice, but with the passage of time things have changed and I am not afraid.*

*(SK, 48, LHW peri-urban, 1996)*

Most LHWs did not have an intermediary to ease the initial contact and they had to introduce themselves to their communities. They had to put in extra effort, even paying multiple visits to the same household. Gaining entry into a household was considered an important milestone towards gaining access to the family inside; LHWs therefore engaged with household members to facilitate this. Some LHWs initially solicited help from influential members of their communities; the LHWs at times took a member of their immediate families with them, especially during the registration of households. Some LHWs, like Khalida, handled these issues by involving prominent women in the community to help them gain access.



*I met a few women who were quite outspoken, and chose five of them for my health committee; I also sought their help for completing the family register. In my community, educated individuals usually cooperated, but many others raised a lot of questions. Without these women's help I would not have achieved anything. Many people just rebuffed me, saying they could not tell anything and asked me to come later. I did not argue with them and visited them again on another day. Such difficulties continued for quite some time, but over time we motivated the people and they have started trusting us.*

*(KA, 54, LHW rural, 1995)*

A few health workers informed their community about their selection and training as LHWs before commencing field visits. These LHWs belonged to predominantly rural settings. When they visited households formally, the community already knew about their training as LHWs at the local health centre. This was more true for LHWs living in vicinity of the health centre. Lack of familiarity was more of a problem for LHWs who had just moved into a new community in a peri-urban area or from somewhere else after marriage. When they started their work, they faced a different dilemma: how to gain trust of their community. Because of this, the initial registration of households was tedious and required a lot of patience, as Sughra described.

*I found the process of registration challenging as I had not lived here earlier and did not know these people. I came here to settle after I got this job and I made acquaintances on the basis of this job. I used to go from door to door, but writing the names was difficult as no one wanted to share information. I used to tell them the reasons for registration, but convincing them on this took a long time.*

*(SU, 41, LHW peri-urban, 1996)*

In many areas where the catchment population was scattered, the distances added to the LHWs woes.

*When I went into the field for the first time, visiting households was hard as the houses were scattered at a distance from each other. Visiting homes was not an easy matter, but I thought, I have put in such a lot of effort in training, I might as well endure this as best as I can, and that is how I managed.*

*(SP, 38, LHW rural, 1999)*

Collecting community-based, health-related household information through the registration of catchment-area households was a key function of LHWs. Thus, asking for household information was an unavoidable necessity for all LHWs. They found their initial fieldwork very challenging, as households were suspicious of women knocking at their doors, inquiring about their intimate details, and then putting everything into writing on their registers. Many people would not share information, thinking LHWs could be fraudsters. Due to the higher turnover of the population, registering individuals in peri-urban communities was reportedly a very difficult experience to that in a more stable rural area where most of the people already knew each other.

Another issue that the LHWs faced during registration was that they sought some information that the community considered private and confidential, households were not willing to share this publicly, especially regarding family planning. Often it was necessary to seek support of other members of the community, e.g. the women's and men's health committees, to overcome people's lack of knowledge about the LHWs. Once the people were aware of the purpose of registration, the LHWs' job was much easier.

*When I went for the first time, some people did not cooperate during the registration of households. Some openly declared that they would not allow this; especially the Pashtuns objected. The people in my community whom we already knew did not pose a problem and cooperated. However, people who came from outside the community objected, but later on we were able to register them, too.*

*(SA, 41, LHW peri-rural, 1998)*

In the peri-urban communities, where there had been an influx from other parts of the country over time, some households refused to give their details. One LHW highlighted this dilemma, while comparing her initial registration in late 1990s with a similar exercise she carried out recently.

*The registration conducted decades ago was a good experience as all of my catchment population was local. I visited door to door with my family register, and the people treated me just like a family member. There was no problem at all. But now the landholdings have been sold and different kinds of people*

*have come [to reside here]. It is difficult to visit every home as I don't know who they are and where they come from. I am updating my family registers and unless a neighbour who knows the new residents accompanies me I do not enter their homes. Registered temporary tenants leave often, posing another problem.*

*(ZU, 42, LHW peri-urban, 1999)*

When the NP was a new initiative, people were unaware of the need for this data collection and understandably avoided giving details about their families as they did not understand the reason behind the LHWs inquiries. Venturing into the field was the third transition the LHWs underwent since joining as health workers. There have been concerns regarding mobility of the LHWs right from the very beginning. The gender norms in the communities proscribe free mobility of the women who are supposed to be confined in their homes. The LHWs faced difficulties in this regard but during the process, the agency or power within enabled them to overcome this barrier. The household visits contributed in formal socialisation of women in their new role as LHWs. The visibility of the LHWs during these community visits also influenced their work practices and forthcoming identity in the households and communities.

When the NP was launched, there was a principle decision that married women would be given preference for the job of LHW. The social environment in which LHWs were supposed to work was less likely to accept an unmarried woman as a health worker, and families were also less likely to allow her to visit their homes. Therefore, most of the LHWs who were selected were married. In many areas, unmarried women, divorcees and widows were also selected, in the absence of other eligible women. Unmarried LHWs reportedly encountered various issues, especially regarding their mobility in the community due to their family concerns.

*If a person is married it is not a problem, but in the case of unmarried women like me, there are some problems... like my brother objects when he hears something [nasty], although he knows now that there is no problem in reality, people just spread rumours.*

*(TB, 36, LHW rural, 2007)*

Some LHWs were unmarried when they joined the NP and married later on and could compare their experiences. Sabira LHW recalled the difficulties she faced for a brief

period when she was unmarried, and she thus felt that married LHWs were better suited for the job.

*When I joined as a LHW being unmarried was an issue. I got married after my training, but LHWs who are unmarried have to listen to comments like before marriage she is getting out of her house and she is this and that sort of a woman. I know women can be under a lot of pressure, but in my opinion they should not become LHWs if they are unmarried [because] they cannot enquire about the problems faced by women and cannot talk openly. I think it is easy for married women as they can talk openly. Most LHWs in my class were married and it was difficult to understand their problems. They used to say that it would be difficult for me to work as an [unmarried] LHW. They used to wonder how the women in field would share their problems with me and how would I advise them.*

(SB, 25, LHW rural, 2009)

As an experienced health worker, Nasreen had come across a few unmarried LHWs during the course of her work and explained the difficulties they might face gaining entry into the community, suggesting that LHWs should preferably be married.

*If an unmarried young woman visits me, she will hesitate because she does not have enough experience or self-confidence. We go and greet women: "How are you? Are you well? It has been two three months after the delivery, is your child okay? You have two children, what is your programme, think about spacing." We have self-confidence because of our age and having gone through this process ourselves, but the unmarried cannot do like this. The married ones can talk with another woman more openly.*

(NA, 51, LHW rural, 1996)

The socialisation of the unmarried LHWs was a bit different as they were more hesitant and reluctant. In a patriarchal society where the gender norms put restrictions on women generally the intensity is more in case of unmarried women. Therefore, unmarried LHWs faced more problems in terms of their acceptability and mobility and even the women themselves had reservations regarding the unmarried health workers.

#### 6.4 Being chaperoned: Coping with mobility in the community

The LHWs were deployed in communities where according to gender norms; women were not encouraged to visit a neighbourhood without family familiarity or a specific purpose. Although the hesitation to visit was more pronounced among the unmarried LHWs, even the married ones, who were born and raised in the same community, were equally reluctant. As the LHWs left their homes to serve in the community, their movement and activities were guided to a large extent by gender concerns, the foremost being their own preference to be chaperoned during household visits. In beginning, almost all of the LHWs were accompanied by someone when venturing outside the home, especially in the initial phase of registration. Being women in a gendered society, they found moving around with a chaperone culturally more acceptable in their communities.

The extent to which LHWs were escorted depended on the individual's age, family structure, terrain and nature of the catchment area population (i.e. old locals or new residents). In some cases, the chaperone also served as an LHW's facilitator in the community, as in case of Sughra, where her sister who was a teacher in the area accompanied her and introduced to their community. Most of the LHWs were accompanied by someone from their own family, such as a parent, sister, mother-in-law, sister-in-law, their own children or those of relative's. With the passage of time, this practice lessened and most of the LHWs conducted community visits alone on their own after a few years. Khalida, for example, was accompanied by someone for quite a while.

*In beginning, I used to take my sons along as they were small, but once I had registered my community there was a woman with me. Now I go alone, but I took someone along for four or five years and at that time I was young and my age was such that I did not go alone.*

*(KA, 54, LHW rural, 1995)*

LHWs favoured adult females from their own household as chaperones, especially during their initial field visits. Some even took their mothers-in-law along, although

more often it was their own sister or sister-in-law, depending on where the LHW was residing.

The motive for taking someone along also differed. Sometimes it was because the nature of the community or the terrain was unfamiliar; sometimes it was because an LHW considered two people were better than one for such visits. The distance to be covered in the community was also a consideration for taking someone along. Often the idea of visiting unknown people made LHWs apprehensive, and they took someone more familiar with the neighbourhood with them, particularly in the beginning to ease the process of registration of households. The LHWs were often mindful of their own weaknesses, which they tried to counter by taking an experienced individual with them. In many instances, they were accompanied only by a child, either their own son or daughter or someone else's child, just to escort them and help them move around in their community in a respectable manner. Mehtab and Khalida were accompanied by their children for years.

In the beginning, some LHWs were worried and unsure what was in store for them in the community. Many women took another LHW or a female neighbour along when they visited the households, a practice they discontinued over time. One LHW described her early experiences in a remote village, explaining, how she relied on a chaperone during her initial visits.

*Before marriage, no one knew me as I grew up in a different village, and after marriage I only used to visit the homes of close relatives; that, too, on special occasions. When I started this job, I had to visit daily. In beginning I took someone along, mostly my nephew, another relative or a small child. Once I had visited a household, I could revisit with ease as people knew me.*

*(SP, 38, LHW rural, 1999)*

There were exceptions to this norm, however. Several LHWs conducted household visits households on their own; others, like Nasreen, did not feel the need to take anyone along, not even on their initial visits. Some women said that there was no need, as the local residents in the village were well-acquainted, having known each

other for generations. Some LHWs worked in areas where they felt it was necessary to have someone accompany them, as these places were not considered safe for a woman alone. One such LHW lived in an area where women do not leave their houses alone therefore; she always brought someone with her on field visits. Nasreen, while acknowledging the need of some LHWs to take someone along, felt that it was merely an excuse in most cases.

*When LHWs visit the field, some are unmarried and their parents are worried about them. It may be justified to take someone along due to terrain and unknown people, but for LHWs who are working in their own familiar surroundings, taking someone along is just an excuse!*

*(NA, 51, LHW rural, 1996)*

In beginning LHWs were hesitant to visit the households in their communities alone and were chaperoned for cultural acceptability of their mobility. In most cases the LHWs did not deviate from the norm and socialised based on the routine practices of women and took a chaperone along. A few LHWs still prefer to take a child along with them as a companion. The LHWs had direct interaction with the women in the households and the role of chaperone was mostly to facilitate mobility in their neighbourhood. Initially they were chaperoned to the health centre by men in their families. However, with the passage of time the LHWs accompanied each other especially when they visited for monthly meetings or other activities.

### **6.5 ‘Loafing’ around: The challenge of home visits**

One of the main tasks designated to LHWs was to increase the access of women to health services in their community. However, for this purpose, LHWs were required to reach out to families through regular home visits. This crucial component in the design of the NP, though logical and beneficial from the community’s point of view, generated a lot of negativity for LHWs. The family members and the community often looked down upon home visits. The experience of one LHW with her mother-in-law illustrates this point.

*My mother-in-law still taunts me, “You go from door to door taking your bag along!” Even after so many years, no one is willing to do this work in my area. If the woman is willing, her family members would never allow her to,*

*going as far as threatening to kill her if she doesn't listen. This [house visiting] is considered a huge insult in our village, and these kind of women (referring to herself) are called 'loafer [women]' implying that they are up to no good.*

*(RS, 35, LHW rural, 2009)*

It is important to note that members of the family and/or community who held this perspective equated these household visits with loafing or roaming aimlessly, as they thought they were offensive and against prevailing cultural and religious norms. Therefore, LHWs strived to convince these individuals and change their views.

*In the beginning, some relatives complained to my husband regarding my household visits, this and that, but I told him that if you have trust in me, I will visit, but if you have no trust, what will I achieve by continuing my job; as my husband and family had trust [in me], they did not stop me anymore.*

*(SB, 25, LHW rural, 2009)*

Even those LHWs whose immediate family members were supportive and where females in their extended family were already in full-time employment faced major objections to this specific kind of job, as it involved visiting households in their community. As part of their job, LHWs made regular visits to the households in their community, however, some male family members considered knocking on doors and waiting outside houses highly objectionable and a personal insult to the whole family. Sughra's brothers-in-law, for example, regularly complained about this.

*I faced a lot of difficulties and believe me, it was a difficult to do house visits. I could manage only because of my husband's support. When I left my house, my brothers-in-laws used to object very strongly. They used to say, "She keeps on standing outside the houses for hours at end and no one comes out and this is our insult". My husband and my parents supported me, so I did not have to discontinue my job. I tried not to listen to anyone and kept telling myself that I had a job to do.*

*(SU, 41, LHW peri-urban, 1996)*

The gender norms in the study area did not encourage the mobility of women and were against their being visible in public. While this was part of the socialising process of LHWs but still was considered a negative aspect of their work by



community and those around them. These house visits were however, important part of the socialisation and work practices of the LHWs.

## **6.6 Mothers-in-laws: Gatekeepers of traditions**

Most of the households in the LHWs' catchment areas comprised of joint or extended families. Whenever present, women's mothers-in-laws played a pivotal role as gatekeepers to their households, being the first point of contact for a visiting LHW. Although their primary targets were the younger women in the households, the LHWs still approached mothers-in-law first, recognising their important position in their households, and tried to win them over to their side. In the beginning of the NP, however, mothers-in-law turned out to be a significant barrier at the household level and a force to be reckoned with. In many cases, they proved quite difficult to persuade and thus LHWs had to make an extra effort in this regard. The following excerpt from a FGD illustrates the initial relationships between LHWs and mothers-in-law.

*PA: We were admonished in households.*

*YA: Yes, we especially received scolding from mothers-in-law during our household visits. We advised women to visit hospitals for deliveries, especially if it was their first child. The mothers-in-law used to tell us, "We also gave birth [at home]". They used to say that the Dai [TBA] had helped delivered her daughter-in-law so many times, therefore, things would remain the same. We used to convince them with great difficulty to let her daughter-in-law undergo an antenatal check-up to know if everything was fine. Our household visits used to be quite difficult. The mothers-in-law did not allow weighing the children, even some other older women present in households did the same.*

*FB: In beginning, mothers-in-law were not in our control [laughter and giggling by all participants]. As soon as we entered, seeing that the monogram on our bag included family planning insignia, mothers-in-law would object to our visit. Getting their attention was very difficult. These old women valued their old traditions and customs and considered themselves right. In their view, the LHWs were wrong and bent upon spoiling their daughters-in-law.*

*GB: In our area, such mothers-in-law do not exist anymore and now daughters-in-laws have the upper hand.*

*(FGD, LHWs rural)*

The mothers-in-laws usually dealt with health issues in traditional ways, which clashed with the health advice given by the LHWs. The mothers-in-law tried different

traditional remedies on the women and children, and it was difficult to stop them. However, the LHWs acknowledged there has been a change in mother-in-law's attitude. On the whole, they were now more receptive to the LHWs' advice, and at times even facilitated the LHWs in their work. In the last fifteen years, there had been a change in the mother-in-law's attitude. In the beginning, problems faced by the LHWs were not due to men, but the mothers-in-law and other elderly women within in the households.

*The mother-in-laws used to complain that they gave birth at their homes and not in the hospital. Now we advise women to visit hospitals. However, currently when we visit, they inquire about their daughter-in-law's TT injection and referral slips for her hospital delivery.*

*(GB, 34, LHW rural, 2009)*

Now, according to Khalida, some of the mothers-in-law are even promoting family planning, while, in the past, they felt threatened by the presence of the LHW and her advocacy of family-planning methods.

*Earlier, we could not even talk with women in the presence of their mother-in-law, as she would say we are ill-advising their daughters-in-law. "I know you are family planning ones and you have come to stop the babies." That was the way they dealt with us. It is different now; they say that, after the first child, there should be a gap of three to four years and sometimes insist that we should have a word with their daughter-in-law in this regard.*

*(KA, 54, LHW rural, 1995)*

However, in the beginning, convincing the mother-in-law and daughter-in-law dyad was difficult, as one of them often remained unconvinced. Although the targets of LHWs were younger women but one of the barriers which the LHWs came across while accessing them was their mothers in law. They were the gatekeepers of the households and considered part of a problem by LHWs rather than a solution. There was an intergenerational gap and they did not agree with the advice being given to pregnant mothers by LHWs nor were they in favour of immunization of children. Holding traditional beliefs regarding health and health care, they wanted their households to follow the same. The influence of the mother-in-law in traditional society in Pakistan is no doubt strong. The LHWs had to socialise with them and deal

with them in an appropriate manner to liaise with the community households. However, with the passage of time, relationships with the mothers in law changed. The older generation had phased out and mainly replaced by newer female head of households many in past were clients of the LHWs and already aware of their messages. This had changed the engagement dynamics of the LHWs at household level. The LHWs are more experienced and their advanced age has also titled the fulcrum in their advantage, conforming to the gender norms of the communities.

### **6.7 Dais: Custodians of women's health in their communities**

When LHWs were introduced, traditional birth attendants or “*Dais*”, were the most favoured birth attendant in their areas. Communities mainly relied on *Dais* and they were firmly entrenched in these communities. Before the arrival of LHWs, *Dais* were the only health worker active at the community level. Therefore, right at the very start, the NP recognised their importance and thus laid great emphasis on the LHW-*Dai* relationship. The *Dais* covered a wide area and provided a range of services, such as antenatal, natal and postnatal care, including the traditional massage of mothers. At times, more than one *Dai* was providing birthing services in the same area covered by one LHW.

When LHWs were introduced, most of the *Dais* were middle-aged, illiterate women who, without any formal training, performed home deliveries. A decline in women seeking care from *Dais* in the area had been observed. Some of the newer LHWs, especially in peri-urban areas, had not come across a *Dai* as none were active in their catchment area or they did not liaise with her. In last two decades, the focus on *Dais* has gradually diminished due to a paradigm shift in the study area, from home to institutional deliveries. Initially, when the LHWs were trained, they were directed to closely liaise with *Dais*. Due to the latter's importance, the LHWs were directed to include *Dais* in their women's committees and to also report deliveries conducted by the *Dais*.

*The Dai was a member of the LHW's women's health committee. We had briefed LHWs regarding their code of ethics so that she does not become a hurdle in the Dai's work. If the Dai is there and people call her on their own,*

*let the Dai do her work. We wanted all new born children, complications during deliveries, including maternal or neonatal death, conducted by Dais recorded. According to NP policy, no LHW could refer women to the Dais.*

*(JA, Medical Assistant)*

*Dais* were expected to be apprehensive about the introduction of LHWs into their communities. Therefore, LHWs were briefed at the very outset about how to deal with the situation. The LHWs were supposed to liaise with *Dais* who performed deliveries in their area or were living in their catchment area. In beginning, the *Dais* viewed the LHWs as competitors, because they had the advantage of training and direct links to the formal healthcare delivery system, i.e. the health centre. The LHWs had received formal training at the health centres, in contrast the *Dais*' being, largely illiterate and untrained. According to Nasreen, this disparity was a major cause of concern and anxiety amongst the *Dais*.

*In the beginning, the Dais thought we would be conducting deliveries. Due to training, we would know more and as a result they would lose their livelihood. We told them, we will only advise women, but you should also know about your work. They should acquire a certificate so that if any incident happens they do not get in trouble. Like I am an LHW and possess a certificate. If a person comes from anywhere, I am not afraid as I have completed my training.*

*(NA, 51, LHW rural, 1996)*

In 1990s, most deliveries in the study area were being conducted by *Dais* in client's homes. However, in recent years, this trend has changed, as one LHS observed; most of the people in the study area now sought maternity care in hospitals. In the past, home deliveries were common due to social and cultural reasons. In initial phases of the NP, women preferred to give birth at home, seeing this as more private and respectful. If a pregnant woman was taken to the hospital, they had to arrange for a vehicle, therefore, everyone came to know about the imminent delivery. Still, there are sections of community that opt for a home delivery performed by a *Dai*, as she is a cheaper provider and relatively more accessible too.

The *Dais* where present were part of the socialization process of the LHWs more so in the beginning of NP. They were the only health service providers available and

working in the communities. The LHWs especially in the earlier cohorts had to deal with them and in many cases it was a mutually beneficial interaction while in others it was almost non-existent. The engagement with Dais was aligned with gender norms of the communities therefore, there were few issues at the community level. However, there were differences of opinion the way they handled their clients. These issues did impact on the work practices of the LHWs and will be discussed in next chapter in detail.

### **6.8 Dilemma of men in communities: to engage or disengage**

The LHWs live in communities where there is clear demarcation of men and women's roles based on the gender norms. The women were supposed to conform to the seclusion and segregation of the sexes. There were restrictions on women regarding interaction with men outside their families. However, once they opted to become LHWs they routinely come across men. These men with whom LHWs had interactions outside their own home can be divided into four categories. The first and foremost were male healthcare staff; the second, the outreach staff, e.g. polio workers and vaccinators; the third comprised the male members of the households she visited and the fourth, the members of the health committees.

According to NP policy, LHWs were mainly supposed to maintain close liaisons only with the women in the community. Therefore, during household visits, the LHWs usually did not encounter men and men also usually kept their distance from them. When the LHWs visited households during working hours, there were no problems because mostly the men were absent from their homes. Sometimes women requested the LHWs to visit later, as men were present at home, which may reflect the fact that they could not talk openly with the LHWs when men were present in their homes or seclusion was not possible due to unavailable space. Sughra affirmed that their interaction with men during community visits was minimal. .

*Our main point of contact is women in the households as we visit to meet them. We do talk with men, but very rarely. Men know that an LHW has come and they get aside and send their wife. If men are at home, the women take us to a separate room to chat. As we work with women, there are no issues, but if*

*one works with men, then there are problems. The women are like sisters and we talk with them just like our one's own sisters.*

*(SU, 41, LHW peri-urban, 1996)*

Some LHWs described their own experiences in the field, e.g. Nasreen recounted her interaction with a religious man who preferred the women in his family to remain confined to his home. Such men did not approve of the LHWs visiting households and sometimes hurled criticism at them on breaking gender norms.

*Their women observe purdah, but when an LHW knocks at their door, they should not say you've come again just like that with this box of yours! They are scholars of religion and do not consider the fact that a woman has knocked, and the least they can do is talk politely in a good manner with her.*

*(NA, 51, LHW rural, 1996)*

The LHWs often accompanied women needing medical attention to the health centre, but did not provide the same service to the men as cultural norms stipulate that women cannot accompany unrelated men. At times men, sought help regarding some issues, but many LHWs discouraged this, except in special circumstances. If a man from the community came to their health house, the household members might object. However, if the visitor was a male member of the health department, there were fewer issues. The NP has placed strict proscriptions on the male staff based on the prevailing gender norms.

The health committees were introduced as an important component of the NP for the long-term sustainability of the programme. The LHWs were mandated to create a health committee comprising of men. This committee comprised of individuals from the community and was envisaged as support for LHWs at the community level. The constitution of the health committee was included in the LHW's job description, and regular meetings were required. Constituting a men's Health Committee itself was a dilemma, as LHWs had to face a great deal of fear and hesitation. Described Nasreen:

*Every month we met with many unknown individuals to constitute the committee, dreading if we met them too often, what my husband would say. We have a family name to protect! Instead of becoming an LHW, we might get into other problems. Although I was apprehensive, I decided to tackle the issue*

*head on as I had accepted that responsibility. Gradually I realised that we are health workers and the responsibilities we have undertaken should be performed to the best of our abilities. So, the Health Committee was formed, including individuals who were influential and responsive. I met them occasionally and developed and maintained links with them from the health point of view.*

*(NA, 51, LHW rural, 1996)*

The male Health Committees posed problems from the very outset. Although the LHWs were supposed to attend the Health Committee meetings, they usually did not, despite being key members. As an LHS on the ground observed, maybe only fifty percent of the LHWs attended the men's Health Committee meetings; otherwise, her husband or brothers represented her there. As LHW Arshi described

*My husband attends, I don't. As this is for men, he is a committee member too, so he takes part. He has reservations on my attending the meeting and says, if I need information he will provide it, why I should go there? In my area there are about fifty LHWs, hardly anyone sits in the male Health Committee meeting.*

*(AI, 36, LHW peri-urban, 2007)*

The reason why LHWs could not play a role in the men's Health Committees stemmed from cultural inhibitions; as such this role was considered to be culturally inappropriate. By virtue of being female and living in an environment where women are not allowed to directly meet unrelated men, an LHW's representation here becomes difficult. In this society, if an LHW talks to a man, onlookers object. This is why, even though the programme has been going on for decades, the male Health Committees are still not functional according to the managers, supervisors and most of the LHWs. Some LHWs like Khalida admitted that their male Health Committees were not functional, but this was due to a lack of interest or change in context.

Nasreen observed that the LHWs were also supposed to file monthly committees reports, but found it difficult to rationalise activities of these committees and thus to submit monthly reports justifying their utility, if any. The supervisors of the LHWs also acknowledged the inefficiency of the health committees over time. The Men's Committees did not work well primarily because the men were involved in a very cursory way. LHWs gave several reasons why their Health Committees were not

functional. Some reasons pertained to the LHWs themselves, while others were embedded in the community. For example, an LHW was often unable to call upon the participants because she belonged to the same community and did not hold an influential position. Furthermore, according to one LHS, there was no facilitation from the health centre.

The health committees were a community based institution introduced by the NP as a voluntary support for LHWs in their communities. There was no support from the health department for LHWs in this regard. As interaction of LHWs with men was involved in men's health committees, this could not function as envisaged because of prevailing gender norms. These ended up with list of names of family members and relations for official purposes for ticking up the box.

## **6.9 Community embeddedness: An advantage for health workers**

Since the inception of the NP, it is mandatory for an LHW to be a resident of her catchment areas. Therefore, in most cases, LHWs had some prior affinity with their catchment population. As a result, they shared many similarities with the individuals living there and were able to forge relationships with them. Because they were in the vanguard of a new health programme, LHWs were cautious about maintaining the sense that they remained part of the common womenfolk.

*As we already have relations, we are careful, especially about the manner in which we talk to the community. We don't want to give the impression that we know too much. We are equal and like them, therefore, they should not get the feeling that we are superior to them!*

*(AW, 41, LHW rural, 2009)*

As LHWs have access to households, they are essentially the community's first point of contact with the health system. They have, as a result, built lasting relationships with the families in their catchment areas, which is beneficial to them and to the communities they serve. The LHWs reported investing a lot of time and effort into initiating and then improving these relationships.



*AW: While visiting, we meet everyone in the house, get information and learn a lot from the village people. There is a change in attitude of the community; they give us respect share issues regarding health and take advice, too. They are happy to see us and leave all chores to listen to what we have to say. We speak in their language and have developed an understanding, so that they consider us their own.*

*FB: I always prioritise my job, even on occasions such as weddings etc., and people ridicule me for always thinking of my work, but I do not waste such opportunities where women are together and I can reach out to them. Often they discuss their problems and take me in a corner during a get-together. Whenever we meet, I answer their queries and give advice. It feels nice that they ask me instead of going to the doctor.*

*AS: We are from the same area and people knew us already, but the connection that we have now was not there before. The women share all sorts of things with us, do not conceal anything, so we also support them by telling them all that we know.*

*(FGD, LHWs rural)*

The relationships between LHWs and women in their communities evolved over time into a link, and most LHWs appreciated their rapport with women in their communities. Even many women not permitted to go anywhere else visited the health houses of LHWs for information. The LHWs consequently felt valued and respected.

*We talk simply as a friend at the first time, that is what we do and then slowly the women start treating us with respect. When we go to their homes, they see us as their well-wishers and even share their children's problem, their own domestic problems and discuss everything. They value our advice, and ask for more time!*

*(AW, 55, LHW peri-urban, 2003)*

Building these relationships enabled LHWs to extend the reach of their advice, and also to improve their own communication skills, particularly the ability to converse with people.

Most LHWs were keen to express their affiliation with the community, emphasising the strong social links they had developed. As most of the LHWs were local, they appreciated being part of the social fabric of their communities.

*I feel strongly about my community, as our happiness and sorrows are shared. If someone dies or there is a marriage, we reach out, being integral parts of the community. However, the community now recognizes us as health people because we visit their houses as LHWs.*

*(RP, 47, LHW rural, 1996)*

LHWs situated themselves primarily in their own communities, since they lived and worked there. The communities, on the other hand, associated LHWs more with the health centre, as they felt they represented this institution. One LHS lamented this situation.

*They are part of the community, but community members feel LHWs are being paid by health centres, therefore, they are functionaries of the health centre.*

*(SH, LHW Supervisor)*

Contrary to the above observation, most LHWs themselves firmly aligned themselves with their communities, considering their link to the health centres to be rather weak, particularly since they only attended monthly meetings in the centre, were not stationed there, and spent more of their time in their own communities.

*We are not like other employees posted in the centre who are permanent and regular and. have to come daily as this is their place! We are not permanent yet; it might change in future.*

*(SK, 48, LHW peri-urban, 1996)*

## **6.10 Building LHWs relations from individual to collective**

The LHWs were introduced in 1994 and have existed as a workforce ever since. Over the years, they have developed relationships amongst themselves. Individual who have been in close contact with LHWs since the beginning of the NP see these relations in a good vein. The LHWs were in contact with each other not only about their work, but also on a personal level. If there was some event in an LHW's household, like a marriage or death, all health workers attached with a health centre

visited collectively. The LHWs literally considered themselves as one community; therefore, they supported each other, as Khalida describes.

*All of us go together for special events, e.g. if there is marriage of son or daughter of the LHW, we all go together. The vaccinator invited everyone to his son's wedding and all the LHWs went together. If there is a death of an LHW's close relatives, all of us visit to console her. We hire a vehicle and proceed together.*

(KA, 54, LHW rural, 1995)

According to one LHS, the LHWs tried to help each other. If an LHW faced problems in understanding something, those with more experience helped their juniors by sharing their knowledge. They still considered each other part of the LHW community, however, without any differentiation based on experience. The LHWs working in contiguous areas also liaised amongst themselves, especially on work-related issues like vaccination. In the past, there were sometimes disputes over issues like the demarcation of adjacent communities, but these have been long since been solved. Sughra works with other LHWs active in areas that adjoin hers.

*We are three LHWs who are closely located and our boundaries are attached, and if there is a problem and one does not have medicines, her clients come in my area and we solve these problems. We inform each other if a new household arrives and register them. If someone transfers in or out from one place to another, we keep each other informed.*

(SU, 41, LHW peri-urban, 1996)

The LHWs who joined in the earlier cohorts liaised with the new entrants and some even facilitated them in their catchment areas. Most LHWs, however, only meet one another only at their monthly meetings. According to them, because of work and home commitments, they do not have time for building further relationships with other LHWs, although a few women do maintain contact with LHWs living near them. Health workers only work collectively in teams of two during the polio campaigns. In one RHC, there were almost fifty LHWs, and so the monthly meetings had to be conducted in two batches. As one woman said:

*We do not meet the other half of LHWs, even at monthly meetings. Only occasionally do we meet when two classes are combined, otherwise we are separate and there are too many girls and there is only one LHS. She cannot do much, give lessons or tell us things. All day she is busy with checking our reports.*

*(SA, 41, LHW rural, 1998)*

Relationships between LHWs belonging to different phases did exist. Some LHWs, however, only developed close personal ties to women in their own cohort. Newly inducted LHWs faced difficulties when they initially joined training. Some felt those before them were far ahead because of age and experience. It took some time to integrate with other LHWs from the health centre.

*When we joined, our group was together as we had received the training together. The senior LHWs were a separate group, but gradually we became equal and now it is not that obvious who is old or new.*

*(SB, 25, LHW rural, 2009)*

The LHWs acknowledge they are supportive of each other, both in terms of work and domestic issues. In terms of work, they learn from other LHWs, and if they do not understand, they consult each other, which facilitate their understanding. If there is a problem, they try to solve this together. If there is a domestic problem, i.e. family issues, they also cooperate with each other. The support from other LHWs, however, was more evident during their health centres visits rather than in their field.

In the past, LHWs maintained relationships mainly as individuals and not as an organised group. The way the whole NP was organised, each LHW was confined to her own community. The LHWs were held accountable for their individual tasks and responsibilities and were, therefore, more individualistic in their approach. There was no element of collective action except occasional socialisation. Hence, even the LHWs themselves did little to enhance their fraternity, and any sense of communality was missing. It was a case of being so close, yet so far. However, in the recent campaign to regularise their services, LHWs have emerged as a group for the first time.

*The LHWs have emerged as a group in the last few years. In the past, this was not so. The LHWs have joined together at the local and national levels for their rights. They have combined because this is national level issue. Therefore, at the district level, LHWs were organized and well connected and attended meetings.*

*(JA, Medical Assistant)*

The LHWs' collective thinking has increased in recent years and has been instrumental in their struggle for the regularisation of the LHWs cadre by the government. This issue will be taken up further when activism of LHWs regarding their regularisation will be discussed.

### **6.11 Transformative changes in the LHWs**

The LHWs perceived a myriad of changes in their own selves as a result of their training and work experience. As they were only confined to household tasks earlier, working as LHWs was a unique experience, through which they developed “*shaur*”, i.e. awareness and understanding. All except one LHW, namely Mehtab, explicitly described the changes they underwent since becoming LHWs. The significant change in most of the LHWs after adopting the role of LHW is reflected in the following quote.

*The change in me is, I feel like a blind person who gets eyes or one comes from dark into light and can see everything!*

*(SL, 38, LHW peri-rural, 2009)*

LHSs are in contact with the LHWs from the day one and have observed this process of change over the years. They see it as a transformation in the health workers.

*The LHWs come from different communities and households where the environments are completely different. When they join, every girl has a different personality. At the beginning of training, most LHW are lonely. Their attitude, way of talking, dress etc. is different. Gradually they share with each other and emulate something from the trainers and experienced colleagues, developing many similarities during and after their training. In my experience, there is an overall change in LHWs, mostly a great deal of change, which is still going on.*

*(AB, LHW Supervisor)*

Most LHWs acknowledged that they had developed confidence since becoming LHWs. As one LHW said:

*Basically, I was timid and introverted. I did not venture out of my home and was afraid of people. My husband encouraged me to go outside our home and gain experience. To keep myself busy, I became a LHW. Now I intermingle with people and I am better than many; there is a continuing change towards the better.*

*(SO, 35, LHW peri-urban, 2009)*

The LHWs feel they are more confident, especially compared to other women living in their communities. They are active in their demeanour; way of dealing and mingling with people has changed. The biggest change in their personality was reportedly in the way they communicated with people, which contributed to building their self-confidence. Being women in a conservative society, they had lived sheltered lives and found door-to-door visits difficult and challenging at the start. However, the confidence they gained during the course of their work strengthened their resolve to continue with their job.

*One change I feel is that I have developed a lot of confidence; I can easily understand people and deal with them. One feels capable of facing a lot of situations that might be difficult for a woman confined to her home as a housewife. Whatever the situation, one can deal with it.*

*(SK, 41, LHW peri-urban 1998)*

Even a former teacher noted an increase in her confidence level once she started working as an LHW. A LHS who worked in close liaison with the LHWs also observed a visible increase in the LHWs' confidence levels over the years.

*After becoming an, LHW everything changes, the dress, demeanour, and they are very confident. When they come to this health centre, they exhibit a lot more confidence than before.*

*(AB, LHW Supervisor)*

These changes in the persona of LHWs can be attributed to the nature of their job, which involved dealing with the public. The LHWs believed that their training and

work experience significantly enhanced their confidence, which in turn, enabled them to perform their tasks in the communities.

*SK: Great changes .... [Laughter.....]*

*PA: In the beginning, we could not talk to anybody as we were housewives. It had been years since we left school and we were afraid just to see the classroom. But later on, slowly, thank God, we could speak confidently in front of others and give them advice... though hesitantly at first.*

*(FGD, peri-urban)*

The LHWs had to converse with their community members as part of their job, and required good communication skills in order to raise awareness and promote health. This skill apparently improved a lot during their work in the field. Nasreen was in the debating club while at school, but later benefited from the interaction with her community.

*There has been a definite change in me. When I got the opportunity to meet and talk to women in the health context, my ability to communicate developed a lot since I joined as an LHW. I feel empowered as an LHW for I can communicate freely with other persons. I feel all LHWs should be proficient in these skills.*

*(NA, 51, LHW rural, 1996)*

In addition to their communication skills, most of the LHWs developed a keen sense of judging the needs of their audience before imparting health advice. Said Sughra:

*One change in my personality is that I have developed the art of speaking after talking with so many mothers. I have an awareness of where I am and who I am taking to, so that I can convey health messages of all types.*

*(SU, 41, LHW peri-urban, 1996)*

An experienced LHV was impressed with the way the LHWs had developed and transformed in their communication skills,

*They have developed an awareness to leave their homes and do something for themselves and their family. They have changed a lot and learned how to speak. They are now audacious and can talk in the community. Make them to*

*stand anywhere, they can talk. They can compete with their household members, community members or whoever, surely they do speak!*

*(BS, LHV)*

The health managers shared similar views about the change in the LHWs, while appreciating the role of training in building their confidence. Experience of visiting households and facing difficulties at health centres and in the field also helped develop the LHWs' perseverance. The majority felt that the other women in their communities, confined to their homes, lacked patience, which is an essential attribute of the LHW's work. The LHWs also described making a conscious effort to change and acquire skills to cope with people, particularly those that enabled them to pursue their work and not retaliate in the case of adverse remarks.

*SUB: When we listen to the others and whatever anyone says, we have to do what is needed to improve their health and visit their houses.*

*NB: There are women who say, "You come daily; don't you have any housework to do at home?" Whatever they say, we have to do our duty; even if they make fun of us, we still visit their homes.*

*GN: We realise that we do not think like housebound women anymore. Our minds are more open, and this gives us a sense of achievement.*

*(FGD, peri-urban)*

When visiting households, LHWs had to maintain their composure and bear with the women. Over time, LHWs exhibited a lot of changes, and reportedly became more aware of their surroundings. Visits to households and health centres resulted in contact with a range of people in their catchment areas and these experiences initiated changes in their personalities. An LHV who had been in contact with the LHWs from the outset described it as follows.

*Their status has changed within their homes. In the beginning when I used to visit house of an LHW, she used to be a very rural girl without any proper system of cleaning or decoration. The clothes of the children and the whole family were different. They did not know how to entertain someone in their house and give proper protocol and respect to the guest and how to serve them. Now one can see the changes on entering the house of the LHWs and their houses are clearly different and upgraded from homes of other similar housewives.*

*(BS, LHV)*



The LHWs also focused on their personalities and were conscious about their appearance and their demeanour. They had to be neat and clean and were frequently required to exchange pleasantries with their clients and other people they encountered.

*I have learned a lot on the job, that is, how to respect and value all people. In the past, it was not so, except for people visiting us. But now it is different as I know how to give respect to every person.*

*(SM, 34, LHW rural, 2003)*

Most of LHWs felt that they now looked after their homes more efficiently, and cared about their health and personal appearance, e.g. dress etc. This was accompanied with changes in ways the LHWs talked with women, i.e. more sincerely and politely, in order to make their messages effective. These changes in the LHWs were not only confined to work, but also extended to their own homes.

### **6.12 Izzat and respect**

One term used by most of the LHWs was “*izzat*”, which is an Urdu word meaning personal dignity, honour and personal prestige and which is synonymous with respect. The LHWs gained a lot of respect in their communities. The respect gained by the LHWs from their communities was not immediate or taken for granted. Many LHWs insisted that they had to work very hard to earn this.

*RP: When we started work, the response was not much, but now people value us.*

*AK: Izzat has increased.*

*AW: All the people in our area know us as LHWs and we have a relationship with all households, we listen to them and they listen to us, and we have a connection with each other and we like it.*

*AW: People give respect.*

*FB: We are valued more at home as well... Now that we earn a bit, we have a say in family decisions. We feel that we have some knowledge and information that can help the family members, and now we have gained a good status.*

*GB: Our value has increased and it looks nice.*

*(FGD, rural)*

There has been a change over time and gradually the LHWs were able to enjoy a lot of respect. In the past, their family members wanted some of the LHWs to quit, but now, because of community's positive attitude and good relationships, the LHWs' families also support them. As one LHW said:

*My marriage is out of my relatives. In the beginning, my family members were not very happy with me, but ever since I became an LHW, people value my services, including medicine, referral and accompaniment to hospital. Being an LHW has earned me respect. I also [reciprocate] prioritise their needs over my own, and visit whoever needs me."*

*(MP, 44, LHW rural, 1999)*

The LHWs perceived they had earned a higher status in their community, and that the community appreciated their work. As one LHW stated, her extended family members acknowledged that she had adopted a good profession and also sought her advice; previously, she herself had had doubts about LHWs. Women visited the health houses and followed the advice given by the LHWs; however, all these relationships worked on a reciprocal basis.

*In the community, respect accorded to an LHW is a bilateral issue of give and take. Households respect the LHWs, who make an extra effort, and she also gets a lot of other problems solved and therefore she enjoys a lot of respect in the field.*

*(SH, LHW Supervisor)*

A change in the attitude of certain community members was also reported by the LHWs. Many who were very critical of their work at first were now very appreciative, as we can see in the case of Sughra.

*Now my community and relatives think my work is alright and if there is a problem, they come and seek advice. However, in the beginning, it was different. Now they are proud that their relative is there to look after them and refer them to the hospital if needed, and this has made a huge difference in my izzat.*

*(SU, 41, LHW peri-urban, 1996)*

This positive change was observed not only in the community, but also within their own households, although the reasons for each varied.

*I have seen a lot of changes in our area. The family members of health workers are respectful to her and the LHW's voice is heard and also accepted. However, I do not know how far it is due to her work, but I feel the money she earns also plays an important role.*

(BS, LHV)

One LHW who joined the service three years ago felt her status in her household had changed since she started working.

*Compared to the beginning, there is a great difference in izzat and respect accorded to me. My family gives more respect, both due to my work and the earning. My relations are very good with people, who also give me a lot of respect.*

(MR, 28, LHW rural, 2009)

The LHWs gained respect due to their work and also because of their technical advice, which was available to the women conveniently, on their doorstep. Within the community and immediate family, LHWs developed a certain value or prestige. If there is a health problem, they are often the first point of contact and referral. If their diagnosis holds after a referred case consults a doctor, their respect in eyes of the community increases.

However, in the healthcare facilities, their position was a bit compromised and the treatment they received was not what they expected and made them unhappy. As discussed in on FGD:

*PA: Izzat is also a thing.*

*RB: Not everything can be counted in money.*

*QN: Izzat is the biggest thing.*

*RK: In the field, we get a lot of izzat. ....*

*RK: We do not like to come here to the centre.*

*SA: We do not feel we have izzat at the health centre.*

*QN: We make a registration slip and there is a big queue. The health centre's officials say the doctor has instructed that the LHWs should be given medicine at the end. Once I told the dispenser that I am going home as my duty is over, even then he snubbed me and reluctantly gave the medicine.*

*(FGD, peri-urban)*

The positioning of the LHWs within the health centres and related issues will be discussed in a later chapter in more detail.

### **6.13 Trust**

Home visiting differs from working in a clinic, where a patient visits, is treated and leaves. In home setting, the visits are more intimate and the clients often share and discuss all issues with their LHW. LHWs consequently enjoy a different level of trust due to nature of their work.

*The women treat me with respect and if I visit their home, they know Baji is their well-wisher and they can share with us. They share their children's problems, their own domestic problems, and discuss everything. Often times, when we give them advice, the women remark, "Our burden is light after talking with you".*

*(AI, 36, LHW peri-urban, 2007)*

The LHWs have gradually learned how to create a space within the households they visit.

*One first has to create a space for oneself, and only then someone can trust you and if someone comes and advises us to do this and that. We cannot simply just trust that quickly.*

*(RP, 47, LHW rural, 1996)*

The LHWs felt their community often posed trust in them, especially regarding their specific health activities.

*PA: If there is any campaign, first of all they wait for us. "Our Baji will come. Whatever she says, we will do."*

*YA: Yes, we will do...*

*PA: It is out of the question that someone can go and tell them, you do this, as they will say, "We have our Baji. When she comes, we will do what she advises".*

*YA: We will do whatever she says.*

*PA: People trust us a lot.*

*RK: Believe me, in polio, if a new team comes, their work is less than fifty percent. But when we do it ourselves, it is one hundred percent as we have unlimited access to the houses. If the children are sleeping, they take us to the room and say, "Baji, give the vaccine in the room". With a team, they just inform them, "Our child is sleeping", and many do not want to wake their children for them.*

*RB: They may say that there is no child in the house.*

*RB: And send the team back.*

*RK: If they see the strangers, they say that there is no child in their home. When we visit they know we are from their area, they take us inside their homes.*

*(FGD, peri-urban)*

The LHWs were so trusted by their communities, especially in terms of campaigns and door-to-door activities, that it was difficult for others to replace them during various activities. One LHW also received trust from an unexpected quarter.

*The Pashtun people do not allow their girls to go out of their homes. In my community, they deputed their girls to me on door-to-door polio immunization campaigns. They trust me to such a great extent. They say, "You have spent your life in front of us. Therefore, sending our girl with you is like she is with us", and one girl worked two and a half years with me on polio immunization, both within and outside my community.*

*(RY, 37, LHW peri-urban, 1998)*

Trust and confidentiality are important values in the LHWs' work. Although they visit all of the households in their catchment area, they keep any information they learn secret, not even sharing it with potentially interested parties.

*In my catchment area, people trust me. I can go to a person and vice versa and anyone who cannot visit the BHU can somehow reach me and share her problems. There are many women who want to get a pregnancy test. The woman does not inform even their household members. I ask them to collect urine in the morning; I collect the sample and get their pregnancy test done on their payment. I also give advice about what is needed for child spacing. Even their husbands do not know they are taking contraceptive tablets, and I am the only one who is aware of the secret. Their confidentiality is of the utmost importance.*

*(NA, 51, LHW rural, 1996)*

One LHS observed that the women have bestowed immense confidence in the LHWs,

*The LHWs who have been working for a long time have gained a lot of confidence in the community. Even if a husband advises a woman on some health matter, she will agree with him but later on consults the LHW for sure. The LHWs have also been advised that all such information should be confidential; therefore the LHW's perform her tasks with confidentiality.*

*(AB, LHW Supervisor)*

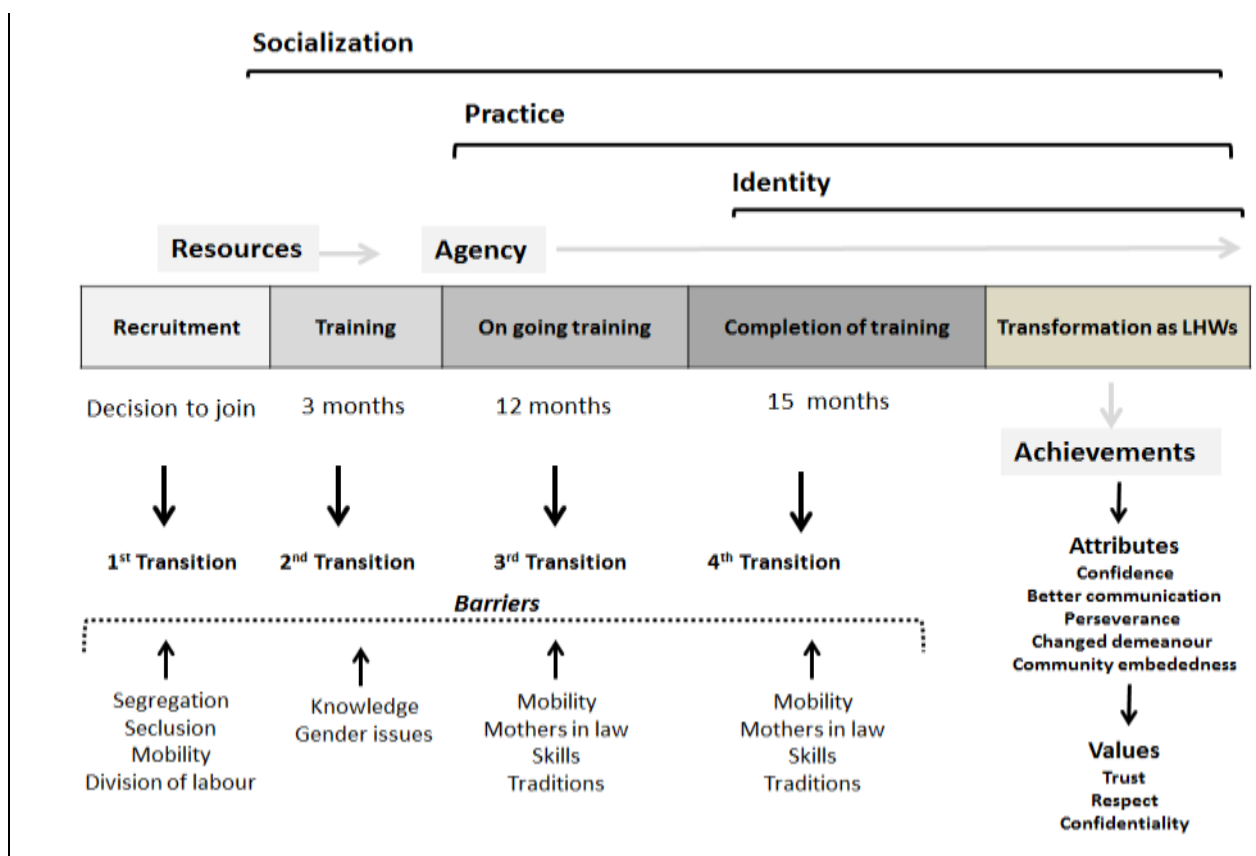
## **6.14 Conclusions**

The LHWs were introduced by the NP in 1994 within the existing district health system. The health workers were situated at the interface of communities and the health system. The women who volunteered to serve as LHWs were, mostly housewives confined to their homes. Over the years after joining as health workers these women had underwent many changes. They evolved and achieved a unique identity as a result of interaction with the health centre staff and community households. There were two aspects of the LHWs' socialisation one being social and other technical. The transformative process the LHWs experienced entailed their recruitment, training followed by their work in communities. The formal socialisation of the LHWs commenced with their training. This was the first encounter and interaction between the LHWs and their trainers. This was challenging both for the trainers and the newly inducted LHWs. The former had never come across health workers nor possessed any prior training experience. The newly inducted LHWs on the other hand included women who were confined to their homes before joining as

LHWs. Therefore, initially training of LHWs was a learning experience for all stakeholders involved, including LHWs.

The objective of the training was to impart knowledge and skills to the LHWs to enable them to work as health workers and provide basic PHC services in their communities. The LHWs underwent four transitory phases during their socialization process. There was a short anticipatory phase prior to the commencement of their training. The next three phases were more inclusive and participatory due to a close interaction between the LHWs and their trainers. The LHWs were deployed in their communities after three months of their mandatory training. Thereafter, they endeavoured to create a space for themselves amid various challenges especially gaining entry into the households. The transitory process and trajectories of the LHWs in their formative stages is summarized below in Figure No. 6.1. The various important events and processes contribute in the development of LHWs at different stages of their work life.

**Fig: 6.1 Socialization and transformation of the LHWs**



The training of LHWs can be considered as a resource in a broader sense as this enhanced their ability. The skills and knowledge gained enabled LHWs development within different institutional contexts i.e. the communities and health centres. This was the first phase of their socialisation as health workers. Training can be considered as type of technical socialisation with long term implications for LHWs. This no doubt prepared them for their future role as knowledgeable and skilled health workers in the health system. This also contributed in their work practices and also towards their future development of a health worker identity. Without this exposure it would have been difficult for these women to adopt their new role.

The contextual factors played an important role in the socialisation and development of women as LHWs. The predominant challenges faced by LHWs were mainly related to the prevailing gender norms. The interaction with the health centre supported the technical aspects of the LHWs' role as health workers. The socialisation with community based actors such as members of households; especially mothers-in-law and Dais were important from the social domain. The LHWs were introduced to improve access of women to maternal and child health and reduce the existing gender differentials. The LHWs themselves however, were constrained by the same gender constraints as their clients. However, as individuals they were able to leave their homes and pursue work overcoming many gender related barriers themselves. Over the years they were able to engage the female stakeholders but failed to involve men from her communities in any meaningful activities. This was primarily due to the gender related constraints foremost being, proscriptions on interaction of unrelated men and women. In addition the NP policies were also not very encouraging as these did not challenge the structural aspects of gender norms and seemingly favoured the status quo. This resulted in socialization of the LHWs in a gender segregated manner aligned with the societal norms. The NP focus was on promoting LHWs as extensions of health services rather than agents of change in their communities therefore, there was no impetus or consideration of many contextual factors.

The conceptual framework suggested by Naila Kabeer regarding women's empowerment delineates three dimensions. The first being resources which are a part of the preconditions of empowerment. The secondly is agency which is as an aspect



of process and thirdly achievements which are measures of the outcomes. The training of LHWs can be considered as a resource in a broader sense as this enhanced their ability. The skills and knowledge enabled LHWs in development within different institutional contexts i.e. establishment of social relationships with the health center, households and community. These factors overtime contributed in their development as health workers. The involvement of LHWs in various activities brought about a change in them. The socialization gave meaning, motivation and purpose of being a health worker which led to their personal agency. This process enabled them to overcome initial barriers and despite the social constraints developed as health workers within their patriarchal context. The agency was not transformative as they did not oppose the existing norm but more or less followed the norm only partly digressing. In many respects they did defy the existing community norms to work as health workers.

These women prior to joining as health workers were living a life of segregation and seclusion in their communities. Moreover, their interaction and mobility within community was confined. Their experiences after adopting the role of LHW were different and based on their training and experiential learning their socialisation occurred at various levels. Over the years a transformative change in them as individuals was their achievement. The novice women who volunteered as LHWs had developed confidence, better communication skills, perseverance and an overall change in their demeanour as a result of their work. They have also inculcated values of trust and confidentiality. This did not occur overnight and was result of years of painstaking efforts. However, these changes were not evenly distributed nor across the board. The women who joined as LHWs nonetheless, evolved into new persons within their own communities through socialisation.

# Chapter VII

## Situational ownership: From induction to integration

### 7.1 Introduction

The LHWs were introduced in Pakistan, in mid 1990s as the maternal and child mortality indicators were unacceptably high. One identified factor for the poor maternal and child health was lack of access of women and children to the health services. The main objective of the NP was to enhance their access using LHWs and attempt to mitigate the gender barriers being faced by high risk groups in their communities. The LHWs were trained and deployed in their own communities to support various health activities of the district health system.

In the first section of this chapter, central work practices of the LHWs are discussed. The involvement of LHWs in supporting certain activities such as immunization and polio campaigns is presented here. Another important task expected from LHWs was developing referral links between the clients and health centres. The LHWs' experiences in this regard are discussed. The LHWs' interaction with Dais, an important actor in their communities is also presented next.

In the second section the burden on LHWs due to their multi-tasking is presented. The LHWs were envisaged as multiple purpose workers however, over the years the work load on them has increased with addition of newer task and responsibilities. These included both field and health centre based duties. The challenges around these work practices are discussed in this section.

In the third section the issues of skill development of LHWs over and above those expected from them will be discussed. Many LHWs have up scaled their skills posing a challenge as this leads to multifarious manifestations presented here.

In the fourth section an overview of the work-life balance of the LHWs is described. The LHWs are working in communities within specific gender norms. The women are supposed to be mainly involved in household work. Therefore, LHWs faced

challenges balancing both the work and family. In addition these women now as earners had to manage the money matter also. An overview of how changes in their financial situation impacted on their household is also presented. In the end a brief conclusion sums up the main findings of the chapter.

## **7.2 Extenders of health services: Contribution of the LHWs in communities**

The LHWs were introduced in mid 1990s at a time when the country's mother and children health indicators were unacceptably high. They were envisaged as agents of change in their communities. The LHWs were well-aware of this fact and recognised their own contribution in improving the health situation in their catchment areas, particularly in terms of raising women's awareness. At the outset of the NP, LHWs' own medical knowledge was negligible. Although many were mothers themselves, their understanding of maternal and child health issues was limited. The LHWs were imparted essential knowledge during training before commencing their household visits. Once in their communities the health workers were faced by an audience entrenched in old traditions and practices. They had to convince families, especially mothers-in-law, about the importance of mother and child healthcare as well as warn them about the often harmful traditional practices including those used by *Dais*. Over the years many improvements occurred in the health status of communities, which the LHWs attribute to their own efforts, as we can see in the following excerpts from a FGD.

*TB: When the NP was initiated, the birth as well as death rates of infants was very high. We were supposed to raise awareness among the community to prevent diseases and reduce mortality in women and children. The focus of our training was on saving the lives of mother and children, and we [think we] did a good job in this regard.*

*FB: When we started [work], the children's death rate was high. After two to four year, fewer deaths occurred. Now such deaths are a rare event. I would say eighty per cent, if not more, is our contribution.*

*SS: [Earlier], mothers did not care about their health and nutrition. We told them that if a woman is healthy, her child will enjoy good health, emphasising this point and giving advice accordingly.*

*FQ: When we started work, women did not know about vaccinations, they used to ask, “Why get vaccinated?”*

*GB: Yes, they did not want to get injections.*

*AW: In the past, no one knew that TT injections are given in pregnancy. Now they themselves inquire about the dates for the first and second injection! In the past, mothers did not know BCG was given at birth. Now they themselves ask when the vaccinator will come and their child will be vaccinated.*

*SB: There has been a big change since we started.*

*TB: We raised awareness among families and therefore, immunization has increased.*

*(FGD, LHWs rural)*

The LHWs felt over the years there had been a major change in the health-seeking behaviour of women because of their organised, persistent efforts to raise awareness. The women listened to them and accepted their advice as LHWs were considered to be knowledgeable. Not only did the mothers get immunized themselves, they also brought their children in for vaccinations. The LHWs perceived that their efforts in raising awareness and removing misconceptions regarding immunization, especially in the case of pregnant women, had borne fruit.

*When we started our work, people did not get vaccinations as they did not believe in prevention. Grandmothers used to say, look at our children, nothing happened to them [without vaccination]. The people were gradually educated about TT vaccinations for pregnant women. We informed them, if you get the measles vaccine, there can still be measles, but not as severe as without the immunization.*

*(SA, 41, LHW rural, 1998)*

The media was considered to be an important factor in this improved awareness, since access to various channels of communication had gotten better over the years. The LHWs felt their communities were better informed because the information they received from them was reinforced by messages received from TV and other sources. A major change the LHWs perceived over time was a shift from their initial, one-way

interaction with the community to a two-way relationship, whereby women proactively seek advice from them.

*Now people have more awareness than before. In the past, people did not have much sense, but now they ask about everything; about spacing, injections of children and even illness. If someone is sick in their home, they want to know where they should take the patient and similar things.*

*(RY, 37, LHW peri-rural, 1998)*

According to the LHWs, women's improved levels of education in the past few decades is reflected in an increased awareness about their health needs, which, in turn, has led to an increase in utilization of the LHWs' health services. A NP manager appreciated that LHWs' contributions in the field were bringing about a positive change in the community.

*The community now questions and demands, e.g. a pregnant woman waits for the LHW to discuss the issues she is facing so she can be referred to a higher facility. This is a huge difference, obviously due to the NP. In the district, maternal and infant mortality has been reduced. If there is an epidemic, people approach the LHWs and demand that their children receive vaccinations. The awareness has increased immensely and people consider LHWs as doctors' alternatives, and take their advice on all matters concerning health.*

*(FT, National Program Manager)*

This reported transition was not only confined to women; other family members also responded more positively to LHWs' advice than they had in the past. LHWs saw that their communities appreciated receiving a variety of services on their doorstep, including polio immunization. Their advice was sought and considered beneficial, and now women are more receptive to the LHWs' health initiatives. Although introduced as agents of change the activities LHWs carried out were as extenders of the health services. They facilitated the uptake of various maternal and child health initiatives e.g. mother and immunization. Their role as supporters or facilitators of structural communities however, was non-existent.

### 7.3 LHWs as a lynchpin in vaccination activities

In the last few years, profound changes have been reported in immunisation within communities. In the beginning, awareness about vaccinations was low, and thus, various stakeholders strived to increase community's access to immunization. The LHWs raised awareness and motivated the community about the importance of vaccinations, which has resulted in improved immunization coverage and efficiency of the vaccinators through LHWs' support in their communities.

*The LHW brings people from their houses, which saves time. She informs them about the schedule and also knows which house has a child needing vaccination from her record, information we would not know otherwise. If we are facilitated by a LHW, we can finish a two-hour job in half an hour. Earlier, we used to make an announcement, and wait for the people to come forward for the injection.*

*(GH, Vaccinator, Field Rural)*

The LHWs played an important role in facilitating the vaccinators' work in the field, especially for non-compliant individuals. The vaccinators made house calls with LHWs for clients unable to visit the health house. LHWs have exact information about the number of children in each household. Therefore, children are not missed during routine check-up or campaigns, as happened earlier, in the absence of LHWs.

LHWs play an important role in persuading their clients to get immunized. The communities were reluctant to get the TT vaccination administered to unmarried women and girls, for example, and needed convincing by LHWs in the TT vaccination campaign.

*There was a problem with unmarried women of child-bearing age. It was very difficult for me to convince them during the TT injection campaign. In the field, it took me an hour to convince one family. They commonly suspect these are family planning injections. To explain and convince each household one by one takes a lot of time and is difficult.*

*(SM, 34, LHW rural, 2003)*

Over time, community trust in LHWs has increased and, in some cases, their presence is expected by parents during vaccinations. LHWs facilitate immunizations and also give polio drops during campaigns. Earlier, when male vaccinators used to come from outside the community, people did not get their children vaccinated because they did not know the vaccination team. Many LHWs say that, currently, people in their communities will only allow their children to be vaccinated when their LHW, whom they trust is present. Even the vaccinators' trust in the LHWs increased as they felt the LHWs' involvement in vaccination activities was beneficial. Apart from routine vaccinations, LHWs' role in polio days and some emergency situations was generally appreciated by health managers.

*Well, in the LHWs' catchment population, according to the third party evaluation, polio immunization coverage is ninety-five to ninety-eight percent. In addition; the LHWs' activities include vaccination, card filling, register entry, and even TT vaccination in some centres. The LHWs have contributed a lot in measles vaccinations, after being trained by us.*

*(ZU, District Manager)*

The LHWs maintained a family register and kept a record of everyone in their catchment area. The community record was appreciated by the vaccinators, who found this information useful. Nasreen considered the LHWs' records to be even better than the national census, since it was based on the real-time ground situation. LHWs generated the real-time data about the catchment areas they served, which helped in achieving the targets for various health interventions, especially that for vaccinations. The LHWs regularly keep a record of how many people came and left the area. The advantages of accurate data are evident during polio days, as LHWs know the exact number and location of children in their community. This makes them an indispensable member of the vaccination team.

*The information LHWs provide is used in micro-planning the polio programme, as we know the exact numbers. In the recent measles outbreak, the NP had complete community data. So, we knew within one day how many under five-year-old children were there in the area, and this helped us to mop up within twenty-four hours. Similarly, we have records of EPI coverage, including TT and contraceptive use in our community.*

*(ZU, District Manager)*

In Pakistan, the first polio immunization campaign was launched in 1994. LHWs have played an important role in polio campaigns ever since. This task requires considerable time and energy; however, it is this involvement that has gradually linked the LHWs' recognition in the community with the polio campaign rather than with their envisaged identity as health workers. Furthermore, LHWs felt that the community was consequently more receptive to polio vaccinations than before.

*When the vaccination date is approaching, parents ask when the vaccinator will come. Those who are overly anxious themselves bring their children for vaccination. The polio campaigns are advertised on TV and most people accept the polio messages and it is not like it used to be in the past.*

*(SO, 35, LHW peri-urban, 2009)*

During polio campaigns, held several times a year, the LHWs are absolved of all other duties and work actively as polio team members. This was not always easy and the LHWs spoke of the challenges they had to face, including negative comments.

*The main thing is that, although our life and honour is at stake when we leave our homes, polio we still do... knock at every door even if we dread the people living inside. Believe me, during polio days, LHWs have to endure being labelled as "stubborn" and "shameless", with many people asking us what are we trying to achieve by doing all this work.*

*(RK, 35, LHW peri-urban, 2007)*

The polio duties posed unique problems as LHWs had to venture out of their catchment areas and often confronted other issues, such as a lack of recognition, vaccination refusal, inappropriate remuneration, prolonged working hours and even hazards such as dog bites. Many LHWs also became apprehensive and anxious after recent terrorist attacks on polio teams.

*Polio creates a lot of problems for us. Now that these attacks have happened, we are afraid to do polio day. Otherwise we do our work very effectively. We can deal with the women of the area that is not a problem.*

*(TP, 42, LHW peri-urban, 1995)*



The polio staff was full of praise for LHWs' work regarding vaccination coverage, especially during polio campaigns.

*The LHWs have an important role to play in polio. It is as if we have this army of people who know about each and every household, and they are at our disposal. Polio is a success due to the LHWs. If we don't have LHWs, we can do nothing on our own. Once trained, these LHWs can administer the polio drops as they know the children in their community very well.*

*(GH, Vaccinator, Field Rural)*

For the most part, LHWs were regarded as responsible polio team members, contributing significantly towards the success of each campaign, especially where they counteracted any refusals in the area.

*Well, there is a very positive role of an LHW in a polio team, she knows her area, and makes the lists of children available. She is a responsible team member, belonging to the government, so the quality of her work is way above that of the volunteers. LHWs have made an enormous contribution towards the polio campaign. However, the number of campaigns sometimes exceeds ten in a year in certain areas, so knocking on doors again and again is a difficult job for them. Most of the refusals are covered through the LHW, as the area superior and the zone superior accompany her to cover the refusals.*

*(ZU, District Manager)*

The amount of time spent on repeated polio days meant that this contribution was at the cost of other routine duties. In a polio campaign, the LHWs' active participation is around five days before the actual polio day, including centre visits, training and logistical distribution, followed by four days of the campaign, and an additional five days afterwards, where she accompanies the vaccinator to her area to reach any children who had been missed.

The vaccinators responsible for immunisation, however, feel their tasks can be shifted to LHWs to improve immunisation services in their area.

*As far as knowledge is concerned, LHWs have been given lots of information about EPI, maybe even more than us. Earlier, the education level of LHWs was a barrier but now, the LHWs are at least Matric, many are FA, and some are even graduates. So now if you give them training for vaccination, they can do it*

*as well as any vaccinator who is Matric; if he can do it, the LHWs can do it, too.*

*(GH, Vaccinator, Field Rural)*

The LHWs are the mainstay of the immunization activities in their catchment areas. They give a tactical advantage to the health functionaries conducting immunization in their communities. This is true in case of the routine immunization activities or special campaigns. They act as a gender bridge community thus enabling male vaccinators to gain access to their clients which otherwise would have been difficult. The transformation of the LHWs as result of their socialization enables them to carryout various activities not only their own catchment areas but also in polio campaigns outside their communities.

#### **7.4 Challenges in forging referral links**

The LHWs are situated at the interface of health care system and their communities. They were introduced to develop and strengthen links between the two to improve maternal and child health. Their referrals from the community were envisaged as an essential element of this initiative. This activity was supposed to reduce gender based barriers of rural women in accessing health services. The LHWs were supposed to provide very limited curative services. Referral, consequently, was their primary function, and great emphasis was placed on this during their training. A health manager involved with the NP since its inception acknowledged that LHWs' referral task had faltered, although referrals still occurred.

*As far as health centres are concerned, there are some referrals, especially for antenatal check-ups. The LHWs also refer other cases but, the vision about referrals planned in the beginning of the NP could not be realized.*

*(ZU, District Manager)*

The LHWs were directed to refer clients only to their respective health centres. During interviews, the LHWs pointed out numerous gaps in this process, which they mainly attributed to the health centres. Most LHWs were not pleased with the way

their referrals were being dealt with and expressed their concern at the lack of respect their referred clients were accorded by health centre staff.

*Our community gives us a lot of respect. We motivate them to visit the health centre, however the biggest issue is the response at the health centre. When people show our referral slip, at least the health centre staff should realise this is an LHW's patient and deserves some respect. If the referred individuals are not treated well, the community admonishes us in return.*

*(RK, 35, LHW peri-urban, 2007)*

Rather than giving preferential treatment to those individuals bearing LHWs' referral slips, they were neglected and not cared for at the health centres. This reportedly had a negative influence on future referrals by the same LHW, and generally on the overall performance of health workers, as the participants of a FGD attested to at length.

*FQ: When we send patients to the health centre, they are not provided with medicine. The women inform us they visited the health centre, however, instead of providing medicine, the health staff asked her, "Did your LHW not give you any medicine?" Where can I get medicine to give them?*

*SL: When we send our patients with referral slips to the health centre, in my experience no one even bothers to look at the slip, while feedback is a big deal. At times our patients accompanied us when we attended our monthly classes at the health centre, but LHWs were told not to do so by the doctors and LHVs. So what is our value to the RHC?*

*SA: In case we send patients, they are not treated well. The patients not only complain, but react about not getting medicine and refuse to get their children weighed! Often they complain about the health centre, but they are fine with me.*

*(FGD, LHWs peri-urban)*

The general consensus among LHWs was that, on the one hand, referral was the mainstay of the NP, while on the other, that health centre staff discouraged referrals from LHWs. The health workers, however, recognised referral as an integral part of their job and considered this to be an important way of accessing the health services required by their communities. Therefore, the LHWs tried to refer clients, despite the

aforementioned problems. Some LHWs even took the initiative of referring patients to nearby hospitals in case of emergency, fortunately with good results.

The LHWs' job description laid emphasis on the referral of pregnant women. Despite several limitations, their efforts were recognized by many. The LHWs sometimes accompanied their patients to the health centre, especially pregnant women coming for antenatal examination, tetanus toxoid injections and TB screening. Most LHWs were however, discouraged from bringing patients along on their monthly meetings. The LHWs opined that better treatment of their referrals could boost their own position in the community.

*When we refer clients to the health centre, if a client is treated in a good manner and given attention, the community will have more trust in us. In reality, the staff at the health centre throws away the referral slips with disregard, then the women complain that they expected to be given medicine, but that in the centre no one attended to them.*

*(SL, 38, LHW peri-urban, 2009)*

It was not only the LHWs' perceptions that their referrals encountered problems in the health centres. The LHS also expressed same concerns.

*When a pregnant woman or child is serious, even the community demands that LHWs accompany the patient as they have developed these kinds of personal relations. Even if LHWs give a referral slip, it is of no significance as LHWs have observed their referral slips are not honoured or prioritized in any way.*

*(AB, LHW Supervisor)*

The availability of the health care staff was another factor effecting client referrals. The doctors were available in all the health centres in the 1990s; however, none of the doctor's posts were filled at the two BHUs when this study was conducted. Only in the RHCs were both male and female doctors working. In the gendered context in which the LHWs were working, the presence of a female healthcare provider was essential for the referral of female clients. In one of the BHUs, no female healthcare provider, i.e. LHV, was posted for almost a decade. As a result, the LHWs' health-related activities for women and children suffered badly and referrals of women to that health centre came to a virtual standstill.

*We do not have an LHV in the health centre and if we refer pregnant women or those needing family planning injections, there is no one in the centre to look after them. If we refer them to another BHU or RHC, either there are big crowds and no one is examined in a proper manner or not even entertained. Instead of getting into this chaos, the women prefer going to private female healthcare providers.*

*(SP, 38, LHW rural, 1999)*

The absence of an LHV was an impediment to healthcare as women were unwilling to discuss most of their problems with male healthcare providers. The LHWs worked in close liaison with the LHSs who were available, but their clinical skills and scope of work was different. In these situations, their referral role was significantly compromised. The LHWs could openly discuss their female clients' issues with LHVs; however, they could not share in the same way with the male staff, e.g. medical assistants.

*The presence of an LHV at a health centre makes a lot of difference. If the LHV is not present, the pregnant women cannot be examined. If an LHV is there, she can also handle the growth cards for the children. When an LHV was posted, I used to accompany the patients, or just referred pregnant women to the health centre.*

*(SB, 44, LHW rural, 1999)*

The way the referred clients were handled had its own implications for LHWs and their relationship with their community. They wanted the referral system to be effective and expected the patients they referred to be seen on priority with respect. The referral system was also weakened due to a lack of available health facilities at the health centres. As a result, the patients reportedly got fed up with and resentful of the LHWs who had referred them in first place. The disgruntled patients complained that they were neither taken care of nor facilitated. The NP managers acknowledged that the health centres had not upgraded their facilities when the LHWs were introduced; therefore; catering for referral needs was often not up to the required level.

*The patient turnover has increased, but our centres have not improved at the same pace. We do not have the instruments we need, so sometimes referred*

*individuals cannot be treated the way they expect, or have to be advised to visit at another time, which irritates them. So, I think the outputs would have been much more had the facilities improved in addition to the presence of LHWs.*

*(FT, National Program Manager)*

As we have seen, LHWs faced difficulties in referring patients to their designated health centre. However, over the decades, many private healthcare providers, both formal and informal, began working in the near vicinity of the LHWs' catchment areas. NP policy directs LHWs to only refer their clients to public-sector health facilities

*The LHWs always send women to the health centre, and that is what they should do. If they would refer to a private [clinic], it is thought that the LHW might claim part of the fee that the private healthcare practitioners charges patients. The LHWs are directed during their training and follow-up not to refer patients to private healthcare facilities, and in most cases, they don't. They send clients to the health centre, and these refer patients to the referral hospitals.*

*(AB, LHW Supervisor)*

The private sector referral restrictions were placed on LHWs at the start of the NP and remain in force today.

*The LHW still has restriction that she cannot refer a patient directly to a private practitioner or hospital. According to protocol, the LHW should first send patients to their health centre. If the staff thinks there is a need, they refer clients on. The task of the LHW is to advise or guide, and the option lies with the client whether they visit a private or a government doctor. The LHW should not refer to the private sector directly; however, for many patients, the health facility is far and out of the way, so the discretion lies with the patient.*

*(JA, Medical Assistant)*

LHWs were not allowed to have direct contact themselves, or through their clients, with private practitioners of any kind. However, some of the LHWs did work in their clinics for some time after joining the NP. Many LHWs were also approached by private healthcare practitioners to work in their clinics, especially in the peri-urban areas. Most of the LHWs themselves were against referring women to private doctors based on their knowledge and experiences. They considered public-sector hospitals

superior to private healthcare facilities because of the lower cost and better quality of services. The LHWs' attitude may be due to their increased awareness of the public sector due to their training or to a prior affiliation. In the vicinity of the study area, there were many public-sector tertiary-care facilities that were still far away when compared to the private clinics, but which their communities mostly preferred. Only Nasreen was in close liaison with a private healthcare practitioner. She engaged him in her activities by carrying out vaccinations at his clinic and, moreover, involved him in motivating her clients when they refused to get vaccinated.

*I had contact with a hospital, which is closed now. I used to refer patients to the doctor there as she was very good. I referred antenatal women to them as it was nearby. Another private lady doctor offered me money in exchange for referrals. I refused her offer and informed her that I would not indulge in such a thing like sending clients and then take money. I do not get into these things.*

*(NA, 51, LHW rural, 1996)*

Over the years, many LHWs were approached and contacted by clinics and private healthcare providers in their areas. However, the LHWs did not maintain any relation with them and confined their activity to health centres. In a few cases, private practitioners invited LHWs to their clinics and asked for patient referrals in return for financial incentives. The LHWs reportedly refused to do so, however, because it was not permissible in their job, and they were also fearful of the consequences. Although the LHWs did not refer patients to the private sector, patients visited private healthcare services as a matter of course, i.e. via self-referral, since the public-sector referral system was practically non-existent.

### **7.5 Dais: Custodians of women's health in their communities**

Over the years cadre of *Dais* has decreased, but is still not redundant or extinct. The *Dais* are still consulted in the initial stages of labour and for uncomplicated cases. The LHWs, therefore, still perceive a need to warn women about possible dangers of deliveries performed by *Dais*, telling them not to take unnecessary risks. When LHWs started their work, many of them already knew *Dais* in their communities, but their interaction with them has decreased over time. Some LHWs still continue with this

practice. *Dais* were members of the LHW's women health committees in some places, and the LHSs encouraged this relationship. In one case, an educated and trained *Dai* even participated in an LHW's community-awareness sessions for women. On the other end of the continuum, Mehtab reported two maternal deaths in her catchment area recently; both deliveries were performed by the same *Dai*. Mehtab's contact with this *Dai* was cursory. A few LHWs, like Sughra, had developed and maintained close working relations with the *Dais* in their areas.

*There used to be one trained Dai in my area who was really good. Whenever there was a delivery case, she immediately informed me and asked me to come. She moved to another village, but is still in contact with me and my community. However, generally people have given up on Dais and few seek care from them.*

*(SU, 41, LHW peri-urban, 1996)*

The LHWs raised awareness among women in their community regarding basic antenatal and postnatal care. At the same time, they also made communities aware of *Dais'* ill practices. The LHWs were told about the wrong practices *Dais* used, like unhygienic techniques, incorrect birthing practices and the irrational use of injections during delivery. They, in turn, forewarned women during their visits about these, counselling caution in using a *Dai*. Many LHWs were sceptical of the *Dais* practices and shortcomings, as one LHW was shocked to see a *Dai's* bag containing used syringes and therefore, felt justified in warning people about her. There was an interesting case of a *Dai* working in her Pashtun community who offered to partner a LHW in her work; the LHW refused. As *Dais* had realized that LHWs enjoy a good rapport with the women in their own communities, they sometimes approached them for client referrals.

*PR: I have good relations with the Dai in my area. The Dai performs a few cases. She asks me to refer delivery cases, but I never send women to her. I only refer to the government hospital.*

*RS: The Dai just gives massage to the women after child birth. She often complains that I refer women to the hospital instead of her. She offered me money, but I told her, I don't want this money.*

*(FGD, LHWs peri-urban)*



LHWs are more knowledgeable than *Dais* as they attended a regular training course. Because of this knowledge gap, some of the LHWs also tried to increase awareness among the *Dais* and to include them without offending them. Sometimes the *Dais* proactively exchanged information about their clients with concerned LHWs.

*My Dai is very clever and informs me when a woman is that far gone in her pregnancy and has not been vaccinated. She comes and reminds me, although it is my work. I also keep her informed regarding when vaccinator's visit is due.*

(FB, 47, LHW rural, 1998)

Nasreen takes prides in her role in changing the community's attitude about use of injections by the *Dais*. She also took the *Dais* into her confidence, making clear that she is not interested in performing deliveries and that she is there to help. Since she can take women's temperature and blood pressure and knows about the stages of labour, the *Dais* now value her assistance, both during labour and referral. In turn, by attending deliveries, she has also gained useful practical experience. The learning process had been mutually beneficial for both LHW and *Dai*, as in the case of Nasreen and many others like Shaheena.

*There are two untrained old Dais in my area and I am in contact with both. If there is a delivery during the daytime, the Dais inform me so that I can join them. I teach them things they do not know regarding cleanliness, clean hands, clean thread and new blades, as they do not care about this. They are happy as I have knowledge about the complications and danger signs of pregnancy. If there is a complication, I advise them to refer, as it might be dangerous. I am interested in performing deliveries, but as we are not allowed to deliver babies, I stay away from this task. However, if I am allowed, then I will perform deliveries.*

(SP, 38, LHW rural, 1999)

The socialisation of LHWs in their communities included their interaction with the *Dais*. The relationships between the two ranged from being mutually beneficial to inconsequential. The LHWs did not involve the *Dais* in their dialogue with the households. The LHWs maintained a liaison with the *Dais* and did not promote them in their communities. The LHWs however, as promoter of maternal health raised awareness of communities regarding ill practices of *Dais* in their communities. The *Dais* were firmly entrenched in the rural communities in mid 1990s when the LHWs

were introduced but with the passage of time lost their hold even in marginalised communities in recent years.

## 7.6 The burden of multitasking

When the LHWs were introduced, they were assigned some designated tasks. With the passage of time, their role in the health system has increased considerably. The LHWs were already multipurpose workers; however, newly assigned duties added to the burden of their existing responsibilities. Policy makers and health managers realised the importance of LHWs in their communities. Without their help, it is difficult to disseminate messages to households. At the height of the dengue fever epidemic, for example, the government printed huge quantities of pamphlets, which the LHWs then distributed widely. They also visited households and spread the message about dengue prevention and control in their catchment areas within a few days. Where people were illiterate, the LHWs read the information out to household members and answered questions based on their knowledge. Increasingly, whether it is dengue fever, Mother and Child Health week, or TB campaigns, LHWs are involved in every aspect of healthcare.

Over the years, new initiatives have impacted on their work. In the past, they used to administer polio drops at their health house, but later had to provide this service door-to-door. Other additional services, like providing pills for worm infestation, followed the same pattern. In beginning, the LHWs were only involved in polio campaigns; however, over time, other emergencies were added to their workload. Said Nasreen:

*Our workload is increasing day by day. Earlier there was polio; now there is dengue. The LHW is supposed to run around for measles, bird flu for that matter... whatever is there. The LHW, with or without reason, should be ever ready!*

*(NA, 51, LHW rural, 1996)*

LHWs also played a key role during the recent measles outbreaks in the country. The NP managers believed that they could play a key role in epidemic control as epidemiological intelligence agents.

*The presence of LHWs is a great advantage because the Disease Early Warning System is based on the principle of the early detection of cases. In that respect, the LHWs play a very important role, providing health education, and referring the suspicious cases for detection. Wherever there was an outbreak of bird flu, we would go there and train LHWs from that area on how to monitor poultry workers. We did this practically and benefited a lot.*

*(ND, District Manager)*

Similarly, a doctor taking care of TB patients championed actively including LHWs in TB control, especially in the monitoring of treatment and tracing of defaulters.

*In my opinion, the high rate of both TB infection and treatment dropout can be tackled through the active inclusion of LHWs. I have stressed during last few TB meetings that LHWs should be more involved. One advantage is that they can confirm whether a patient is a resident and keep track. Most of the patients are here only for a visit. After a few weeks, we come to know that the person has gone back. At least LHWs can confirm whether the person lives there permanently or not. At present, the involvement of LHWs is minimal and without this, preventing default is very difficult.*

*(KI, Medical Officer, Rural Health Centre)*

Within the RHCs, LHWs were assigned additional duties, labelled as “static duties”, none of which were in their original job description or the NP mandate. According to the district managers, LHWs have no role in the health centres because they are community-based, where their role is pivotal. However, others justified these new duties as the evolving nature of the LHWs’ responsibilities, expecting and urging them to change their schedules accordingly. Some LHWs did not like their duties in the centre and considered these to be outside the purview of their work, since they had opted to work in their communities.

In the RHCs included in this study, LHWs were assigned duties inside the health centres. They were otherwise not considered to be part of the health centre by the staff.

*Some LHWs complain of extra work. I tell them that whatever the office tells us becomes a part of our duty and we have to do it. Not long ago, when our centre was upgraded, this duty was given. Earlier, there was no static duty as such. The LHW would come to the doctor, we used to call them here to learn stuff like antenatal examination, and the doctor also used to teach them, but that is not happening anymore.*

*(AB, LHW Supervisor)*

The LHWs' static duties were very important for health centre staff as they lightened the heavy workload in the RHCs. Although not included in their job descriptions, these duties were very crucial for the smooth running of the health centres, particularly since LHWs subsequently helped to register patients and to deal with the public, including interactions with men. It is pertinent here the gender policy regarding interaction with men was disregarded in this instance.

### **7.7 Acquiring further skills: Over and above the “Call of Duty”**

Primarily given preventive responsibilities, including the treatment of minor ailments, the LHWs differed in opinion about their role in curative services. Many considered curative services to be a subsidiary task. Although most LHWs were aware of their boundaries regarding curative care and prescribing medication, some acquired skills over and above those required, imparted or expected of them. For instance, the LHWs are not taught how to check blood pressure, but many were keen to acquire the know-how and shared their experiences in this context to highlight the usefulness of securing further skills.

*If someone is ill, we can check their body temperature or has high blood pressure, we can also check. Having my own BP apparatus and knowing how to use it is an advantage, and this skill has earned me a lot of respect. Checking blood pressure is beneficial for pregnant women and therefore useful for antenatal check-ups. A lot of people suffer from hepatitis, diabetes and heart problems, therefore, more awareness and training need to be given to the LHWs.*

*(FB, 47, LHW rural, 1998)*

A few LHWs had acquired basic nursing skills while working in private clinics, unlike their counterparts, who had not been exposed to this during formal LHWs training or subsequently at the health centre.

*I have learned basic nursing skills and know how to give injections, intravenous infusions and stitch wounds. However, I do not give injections as we are not allowed. I only administered injections in a clinic under the supervision of a doctor, as in case of a reaction he could handle the situation.*

*(RK, 40, LHW peri-urban, 2003)*

Another LHW who had worked in a surgeon's clinic was of the view that the set of skills she had acquired there were over and above those learnt as an LHW. Several LHWs were able to acquire clinical skills through their own initiative from their respective health centres, and acknowledged these were useful during their household visits. Nasreen expected other LHWs to also do the same.

*I can give injections, take the temperature and check BP and people in my community say we are doctors. I would be humiliated if I was an LHW and I was not able to take temperature if requested by someone. People would taunt me about my work skills. I have seen an illiterate helper pass a cannula and administer glucose infusion. If an LHW does not know these basic things, it is not good. We are attached to this profession and one has to get out of her house and learn from the health centre because nobody is going to come and teach these skills in our home.*

(NA, 51, LHW rural, 1996)

A few LHWs also justified the acquisition as well as the utility of these skills, even defying the rules and regulations and risks involved.

*I know how to give injections, intravenous infusions and check BP. I have learned these things from the BHU. We are not allowed to perform these activities, but in view of the needs of my community, I have to provide such services. I live in a remote village where the nearest doctor is about ten kilometres away. I give an injection if a patient has received an injection before or if there is a problem, i.e. one does not have transport to go to the city. I do not want to annoy anyone, therefore I do provide treatment. If anything happens, then I will get in trouble and everyone will ask who has given me permission to do these things. I give injections, whether they are for pain or vitamins. If someone brings an injection, I just administer it, despite the risk!*

(SP, 38, LHW rural, 1999)

While many LHWs had upgraded their skills through their own effort and were also keen to use them, there were a few who avoided doing so because these tasks e.g. checking blood pressure were not included in their job description or list of responsibilities. Although many LHWs were trained to administer injections, the policy in this regard has been inconsistent, as consequently, has been the LHWs'

practice. Sometimes the supervisors forbade them from administering injections, while on other occasions, they were allowed or even mandated to give injections. Nonetheless, some LHWs defied the advice or complied with the existing policy. Some LHWs like Sughra stated that they refused to administer injections when requested, for fear of being held responsible in case of a reaction or accident. There were, however, two exceptions. Many LHWs administered TT vaccinations during pregnancy, as women were hesitant to get immunised by male vaccinators due to the gender concerns. Furthermore, contraceptive injections were also administered by LHWs in which confidentiality and privacy was involved.

With the passage of time, the LHWs' skills contributed to their identity, even though some of the skills acquired were voluntary and not included in their job description. According to the LHWs, despite having a predominantly preventive role to play, LHWs were at times more inclined towards curative services and portrayed themselves as health practitioners.

*LHWs consider themselves as health providers. Most of them feel their job is to provide medicine, and very few understand they have been recruited for preventive services. There are even some who say they are doctors. They think their sole job is to give medicine; therefore, if there is no medicine, how they can visit the households! They behave like health practitioners, and the community also thinks the same. I have advised the LHWs many times that their job is not giving medicine. They are often told to send patients to the centre and not to treat them, as their job is prevention and not treating disease but still...*

*(NJ, LHV)*

The LHWs were not supposed to be health practitioners; in the beginning, however, they were encouraged to administer medicine to enhance their acceptability to the communities. The LHWs were also supplied a few medicines for use in case of minor ailments. They were supposed to provide these to the women and children in their community in times of need and free of cost.

*Initially, the LHWs were not supposed to be provided with medicine, but on the commencement of their work in the communities, they were supplied with*

*some medicine so that people in their community would listen to what they said and for their community acceptance.*

*(SM, National Program Manager)*

This dispensation of medicines reportedly satisfied the community to a certain extent; however, the women in the community seemed to expect more from the LHWs.

*The women demand medicine from LHWs during their home visits. They complain, the LHWs just talk of giving polio drops and do not provide medicine.*

*(NA, National Program Manager)*

The dilemma was such that, while some LHWs stated that they did not consider themselves to be doctors, the community still had many expectations of them even as health workers, which were beyond their ambit.

*People bring all sorts of medicine, and we do not know about these. We have not been taught anything about these either, so we feel very unhappy that we have not been taught these things, we just advise....*

*(SO, 35, LHW peri-urban, 2009)*

There was a general impression among health centre staff that LHWs were acting as health practitioners in their communities. According to them, some LHWs did exceed their limits by offering curative care.

*Well, there are LHWs who practice and portray themselves as doctors, but not here. There are some areas where this has happened. Well, they have been given training and information only up to a certain level, not as independent health practitioners.*

*(SM, National Program Manager)*

The LHWs were supposed to adhere to the guidelines of the NP, but some did violate these and indulged in curative care, as the coordinator of the NP reported.

*We found that some LHWs resort to quackery. They give injections and prescribe medication. We did report this, and took some action against them. However, we still receive such complaints. Once we come to know of such an activity, we take requisite action. But still such issues keep on coming.*

*(FT, National Program Manager)*

Although the LHWs were supposed to provide some basic medicine for immediate relief, they sometimes exceeded their remit as health workers and acted as doctors, and not simply in name. The district health office was also concerned about LHWs falsely posing as health practitioners.

*LHWs have become quacks themselves. There are many places where LHWs are treating patients independently, although they were only allowed to prescribe some simple medicines and nutrients. A few of them actually started quackery, although they have not been trained to treat health disorders. Although officially they have been asked to explain, no further action has been taken.*

*(ND, District Manager)*

There were fears and apprehension about the LHWs inclination towards curative services, which was regarded as an impediment to their active inclusion in Expanded Programme on Immunization services.

*The potential of LHWs to become health practitioners is a big threat; for this reason, there is controversy around their further training for EPI. The government officials feel LHWs already consider themselves to be doctors, and by allowing them to administer injections, we will further facilitate them in this role.*

*(ZU, District Manager)*

The LHWs were trained in the health centres and were imparted basic knowledge and essential skills essential for their role as health workers. Some of the tasks were assigned to them for which formal training was also given. However, during the continuing socialisation process and experiential learning of the LHWs many of them were able to acquire extra clinical skills. The practice of these skills was seemingly out of their purview and raised questions. The role of a curative medical practitioner in their communities as part of their work practices was however, not encouraged.



## 7.8 Coping strategies for work-life balance

The majority of LHWs were housewives, responsible for all their household chores. Those living in nuclear families looked after all household matters. Even if they were living with their in-laws, LHWs were usually the only women responsible for a major portion of the housework. There is a well delineated role of men and women in their communities. The LHWs were therefore, mandated to look after most of the household activities. They tried to avoid criticism from those around them by ensuring that they completed their household responsibilities early in the morning prior to conducting household visits, or at night, after they had returned. With house and job, LHWs thus ended up having a twenty-four-hour commitment, although their home remained the top priority. Said one LHW:

*I think a woman is [always] a woman and it does not make much of a difference [whether she works or not]. Your home is always the priority, whether you stay at home or go out for a job. The only thing is the one who ventures outside becomes a bit stronger!*

*(SK, 48, LHW peri-urban, 1996)*

Although the LHWs' tasks were well-defined, keeping a balance between work and home increased their burden. Many of their household activities were gender-specific and thus considered outside the ambit of men. The LHWs were therefore supposed to take care of these responsibilities with or without any support.

*They have to look after both the home and the job. The LHWs send their children to school in the morning. Then they do their household chores followed by field visits. These poor souls have to scamper back home to cook food before their children return from school in the afternoon. Mostly there is no support for this. If one has a mother or mother-in-law or sister, that is another thing; however, this happens in a few cases only.*

*(NA, National Program Manager)*

The LHWs acknowledged that their lives had undergone a change and thus recognized the importance of routine and time management. Many LHWs were teachers prior to joining the NP and therefore already used to working outside their

homes. They found the LHW job less hectic and more convenient. Since there were no timing restrictions, they could conduct fieldwork according to their own schedule. An LHW also had the flexibility to catch up on lost work the next day in case she missed a household visit.

As mentioned, most of the LHWs were housewives before taking up this job. During their training and subsequent work in the community, the LHWs reportedly spent considerable time outside their homes. Their family members worried that the home would suffer due to the LHWs' commitments with the NP and opposed their work for this reason. Therefore, the LHWs faced a lot of resistance within their families and they had to be assertive in order to prove that they could look after their families' needs as well as working as health workers. In some cases, the sisters-in-law, mothers-in-law and other family members objected because the women who remained at home had to do the major share of housework to compensate for the LHW's periods of absence from her home.

*In our area, it is the sisters-in-law who do not see eye to eye. The husband's sister objects that her sister-in-law [an LHW] leaves home and the former has to do all the housework in the latter's absence. In such homes, there are a lot of problems and family clashes on this issue.*

*(SH, LHW Supervisor)*

The LHWs were supposed to work in their own communities, a feature distinguishing them from women working outside in institutions. A coping strategy often adopted by LHWs was to handle their increased responsibilities by rearranging and scheduling their day to day activities. One common challenge was the need to be in a state of ever-readiness since they had to venture out of their homes for work. This was in sharp contrast to the other housewives in their neighbourhood, who remained confined to their homes and could do as they pleased. An LHW's job needed fulltime commitment on two fronts and therefore, was quite laborious. For most LHWs, who had been confined to their homes earlier on, this new responsibility brought about a change in their social routine. Although the individual situation of each LHW varied, they all still found this challenging.

*In my life, the difference is that earlier I only did housework. Now I do the household tasks and, in addition, the outside work as an LHW. Life is so busy that I drop dead on my bed at night. There are illnesses or deaths in the family, but we cannot visit anyone, except for on Sunday. That is how busy life is.*

*(RP, 41, LHW peri-urban, 2009)*

Most of the LHWs were married women with small children who also had to be taken care of when they joined the NP. Being of child-bearing age when they joined, many also gave birth to children during their tenure as LHWs. If the LHWs were supported in childcare by family member, e.g. their in-laws or parents, this did not pose much of a problem. In nuclear families in absence of such support, young ones often had to be taken along during their community visits. In one instance, an LHW had to hire a maid to look after her children and home. Nonetheless, childcare was a major issue for most LHWs. At the time of data collection, many LHWs had grown-up children who now provided a helping hand to their mothers. While family members were a source of childcare support for many, some LHWs had to face criticism due to perceived child neglect.

*When I left my girl at home, my extended family commented negatively. They said I was more interested in working for myself, as I used to leave my children in their care.*

*(FQ, 38, LHW rural, 2009)*

This criticism increased when the salary was delayed; then elderly in-laws saw no advantage in continuing with the LHW's job. The individual conditions of the LHWs varied but overall, the families were not in favour of their leaving their children in order to pursue their job.

Because the institution of Lady Health Worker relied on a completely female workforce, it also grappled with maternity issues apart at times other than the mandatory training period. The NP officially granted each LHW twenty days of maternity leave. Female government employees like teachers, doctors, nurses and others are entitled to three months' maternity leave. However, because LHWs were contract employees, they were not granted this privilege.

The LHWs reported facing difficulties if they wanted some leave, contrary to other health staff at the health centre. The amount of leave an LHW was entitled to for childbirth was contrary to the messages they gave to the women in their catchment area.

*AI: I thought we were trained to look after pregnant woman from the first day of pregnancy to fortieth day after birth. When we are in the same situation, we are told to come out of the house for work, just twenty days after delivery. So are we not mothers who have had a delivery? When we educate others, we should also get the same right, shouldn't we? If we go in the field twenty days after delivery, what would those mothers think about us? The community has seen us throughout pregnancy, so they ask us about the outcome, if it was a boy or a girl and about our health. And when we tell them, the next comment is, how can you come in to the field so soon?*

The balancing of work and home activities was challenging for the LHWs. Because of the gender based distribution of labour in their households LHWs had to bear the brunt of double burden of work. Neither the households nor the health system was willing to grant any concessions thus increasing their work load and job stress.

## **7.9 LHWs as gatekeepers of household spending**

The LHWs were often the main gatekeepers of household spending in their families and managed all money matters. Husbands usually handed their earnings over to their wives/LHWs for safekeeping, taking small amounts as and when required. Since the start of the NP, an LHW's stipend was disbursed only through her personal bank account, which either she or the men in her family could access. Most of the LHWs kept their monthly stipend to themselves and spent it in their homes as their needs increased with time. In a very few cases, the LHW's husband insisted that she hand her stipend over to him, at times almost jeopardising the marriage.

The LHWs who had been receiving monthly stipends for quite some time reported a change in their financial situation. These LHWs used the phrase “*khushali aie hai*” in Urdu, which translates as “prosperity has come”. Most LHWs had joined the NP out of *Majboori* as they were finding it difficult to make ends meet. Their stipends

brought relief and support, but a couple of women still supplemented their salary through additional part-time jobs in private clinics.

*I was an ordinary housewife, lost in my own anxieties. When I joined as an LHW for the stipend, my family conditions improved. I was able to stand on my own two feet and contribute toward household expenses. My children, who had stopped attending school earlier, could resume their studies. I also started working part-time in a private clinic.*

(RK, 40, LHW peri-urban, 2003)

For LHWs whose husbands were also working and earning, there was enough for subsistence and their stipend was spent on meeting additional needs.

*I am very happy. I did not withdraw my salary and saved two years' salary and pooled funds with my husband to buy a car. The good thing is that my daughter studies at university and, if needed, we can pick her up and drop her off in our own car. We can also go places in the car. In case of a disagreement, I joke with my husband, "Half the car is mine."*

(FB, 47, LHW rural, 1998)

There were still others who spent their entire earning themselves, while their husbands looked after the household expenses. Widowed LHWs were the main breadwinners in their family, so their stipend was the family's main source of subsistence and survival, as in the case of Mehtab.

*I run the household with the stipend. Previously, because of a lack of funds, it was difficult. Now, with the salary, my expenses are being met. The money I receive is all I have, as after the death of my husband, I live on my own and I have my daughters to look after. I have had no need to borrow money since I started the job. Earlier, it was hard times and we had to borrow and take out loans. Now that is not the case.*

(MB, 52, LHW rural, 1996)

The LHWs' income helped improve financial conditions in their households since their husbands' salary was usually very low. The LHWs acknowledged their contribution to the family income. It was not only their earnings, but also their spending that made LHWs self-sufficient, something which was even appreciated by

their extended family members. The stipend LHWs earned was not substantial, but it solved many financial issues in their families. They were proud that their financial sufficiency enabled them to cater to their needs, as well as putting them in a position to help others, via financial gifts or loans. Some LHWs were also able to construct their own house, which was a great achievement in their context. This also enabled LHWs to move out of their joint family-owned house or a rented accommodation to their own personal living space. One LHW was even the first one in her husband's family to own a house.

The stipend went a long way in meeting needs of the LHWs as described above. However, since the start of the NP, there have been delays in the payment of salaries. The LHWs joined primarily due to their *majboori* and the undue delays increased their problems. At times, there were months without a salary and they had to borrow money for their subsistence and their work also suffered. The delays in salary were a sore point for most LHWs. Not receiving timely salary poses a huge problem for the LHWs, who use this amount to meet their recurrent monthly expenses.

*In the beginning, conditions at home turned so bad even the school fees of my children could not be paid. The school administration was sceptical about the nature of my job and impatient too! While at home, my husband also raised the same question because of the salary delays for months. At times I felt like leaving this job.*

*(RK, 40, LHW peri-urban, 2003)*

Although confronted with financial problems, many LHWs came to terms with the delays in salary. The LHSs also shared their concerns about the delays as these affected the LHWs' motivation and work. It was not only the delays in salary that aggravated the LHWs, but also its amount. The vast majority considered their remuneration to be insufficient and wanted it to be increased.

Many LHWs were very keen to educate their children and also exerted a lot of effort in this regard. The earnings of LHWs contributed in impetus that their *children should get a better education than them*. An LHW, who herself wanted to become a nurse, especially focused on her children's education, despite facing hardship. Her daughter

finished her bachelor's degree and was now pursuing a diploma in dentistry, while her two younger ones were studying in secondary schools. Another LHW sent her two girls to study in a model school<sup>9</sup> in an adjoining city. The children of some of the LHWs from the initial phases had completed their university degrees. Their educational attainments were attributed to the job remuneration of their LHW mothers. Another LHW managed to provide her children with a better education in the absence of any input from her family. Some LHWs who were themselves only educated to middle grade were very keen to educate their children.

*[Because of the stipend] I could afford a master's in political science for my eldest daughter from an out-station university. My son completed engineering and now works abroad. The third daughter did her diploma in electronics and joined the air force as a technician. Two younger sons are in high school. Although the stipend was not much, it helped me in educating my children.*

*(NA, 51, LHW rural, 1996)*

## **7.10 Conclusion**

The LHWs were trained in the health centres during their mandatory training. They were imparted both knowledge and skills during this process. Over time the LHWs transformed and developed into confident health workers as a result of their training and work experience. Their interaction with the health centres and within the community households was a socialisation process which involved both social and technical aspects. This process also impacted on their further professional socialisation and development of their health worker identity.

One major task assigned to the LHWs was, playing a supportive part in the immunization services. The NP laid great emphasis on enhancing the access of women and children to routine immunisation. The LHWs provided a tactical advantage in this regard in three ways firstly they possessed real time information of the community, secondly they were in liaison both with the households' and vaccinators and thirdly they acted as gender mediators in this activity. This created an enabling environment and thus contributed towards improvement in immunisation

---

<sup>9</sup> School providing quality schooling facilities for the children based on modern teaching techniques

activities. The same factors were true in case of polio and other vaccination campaigns. In immunisation activities, LHW inclusion was mandatory and ensured by the health centres failing which LHWs had to face dire consequences. The NP laid emphasis on women and child health therefore; LHWs being female had better access the households as a result of their socialisation and personal relationships with families. The immunisation service in the communities was hugely dependent on the LHWs. The same was true for their deep involvement in the polio activities which have compromised other functions of the health workers. These activities have also contributed in their identity and label as polio workers rather than multipurpose health workers.

The LHWs were introduced to develop referral links between the communities and health centres. The training curriculum laid emphasis on this role and even during the training great importance was given to this activity. However, this link could not be developed as envisaged. The access of clients in the health centres through LHWs did not improve. At the community level link between the LHWs and their clients did exist. However, in case of LHW referrals to health centre this link withered. This resulted in a lost opportunity as one of the main functions of the NP initiation i.e. enhancing community link with health centres could not be realised. This compromised the LHWs position in their communities.

There was a semblance of a situational ownership of health workers on part of the district health system. The LHWs were considered crucial in case of some tasks like polio vaccination activities and immunization where the LHWs' contribution was considered essential and they were also held accountable. At the same time, however, their referrals were disregarded and there were no efforts to strengthen referral links between health centre, LHWs and the community households. Also the NP engaged the LHWs in multiple tasks, whenever required at the health centres. In some health centres the LHWs were even assigned health centre based static tasks that were not included in their role as health workers, in contravention of the NP policies.

The households in LHWs catchment areas were seeking care both from the public as well as the private sector. At community level the LHWs interaction with Dais was

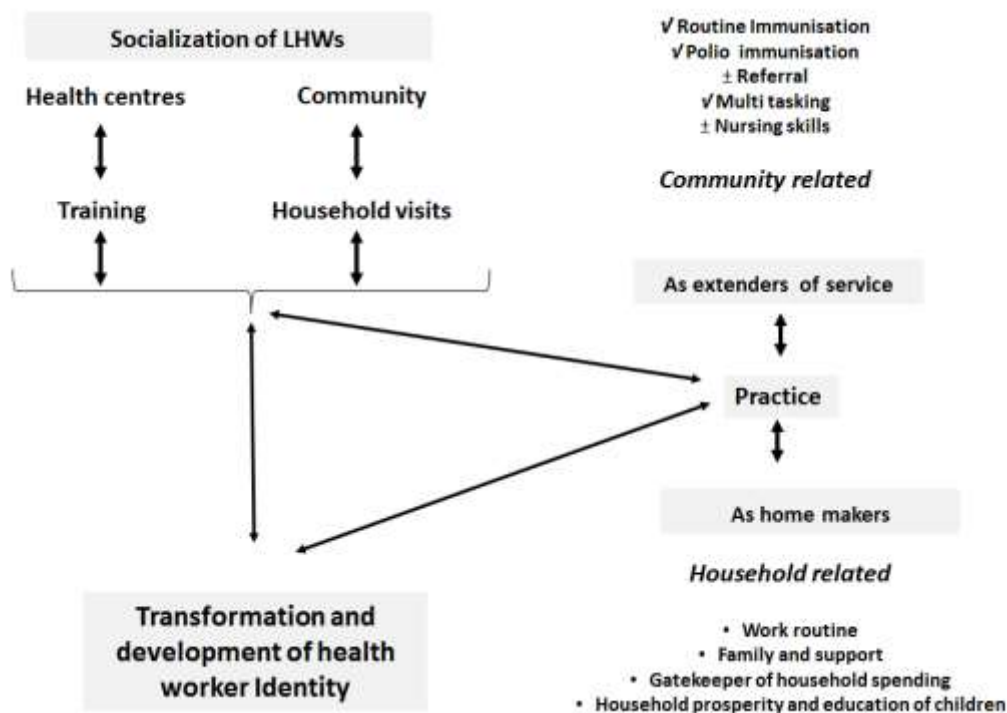


encouraged by health centres while at the same time discouraging their work. Some health workers maintained a link with Dais which was more of an oversight one. However, a few LHWs had two-sided interaction. The NP forbade the LHWs to maintain links with the private sector health practitioners. This was a dilemma in view of the inadequate services provided by the public sector and failure of the referrals at the community and health centre interface. This diluted a lot of efforts being made by the LHWs to enhance access to improve maternal and child health in their communities.

The formal socialisation of the health workers commenced with their training. This process continued with the various work practices of the LHWs. In their work LHWs had interaction with the community as well as the health centre staff. Some of LHWs have been able to improve their technical skills to a higher level either working with doctors in private clinics or from their own health centres due to their personal initiatives. These women did not confine themselves to the basic skills taught and expected from them. In some cases there were concerns that they were misusing their position as a LHW. It was feared they exceeded their role as health workers and were more involved in undertaking curative tasks as health practitioners in their communities.

The socialisation of LHWs and their work practices are interlined with their identity development. There is interplay of these three factors as depicted in Fig. 7.1 below.

**Fig: 7.1 Web of interrelationships socialization, practices and identity of LHWs**



The next chapter will discuss evolution of identity of the LHWs as a result of their socialisation and work practices.

# Chapter VIII

## LHWs' quest for identity

### 8. 1 Introduction

Nine cohorts of LHWs had been trained as health workers in the study area since 1995. Novice rural women were recruited, trained and deployed in their respective communities. Their experiences over time transformed them from housewives into health workers. These LHWs worked at the interface of the community and health centres in the microcosm of the district health system. Social interaction and work practices contributed in their socialisation process, ultimately leading to their identity formation. This chapter explores the issues around the LHWs' identity within the health system. The first section describes the evolution of LHWs' identities over time. Due to the work practices of the LHWs, the communities perceived them differently. I examine how the LHWs were recognised and identified in their communities, primarily based on the scope of their work, at different stages.

In the second section the positioning of the LHWs within the health centres is discussed. The LHWs have been working in the health system for the last two decades. However, the extent of their integration and position within the health centres times was not very clear. This section explores how close the LHWs were to the health staff and their ownership and recognition. In the third section, the LHWs' struggle for regularisation is discussed. The LHWs joined hands and led the struggle across the country in an effort to become regular employees. These efforts were for the change in employment status of LHWs from their contractual to a permanent one. When this study was being conducted, the LHWs were in a transition phase, on the cusp of being inducted into regular government service. The concerns and reservations of district health staff and LHWs at this crucial juncture are presented.

In the fourth section, I explore the LHWs' apprehensions and concerns during and after their regularisation campaign. These women shared their views at a juncture where they were still unsure of the final outcome of their regularisation struggle. There were still doubts and ambiguities in their mind, which is discussed in detail. In the end a brief conclusion sums up the main findings of the chapter.

## **8.2 Embracing a health worker's identity: The emergence of LHWs**

In Pakistan, no community-based health worker existed in the public sector's primary healthcare system prior to the introduction of the LHWs. There were, however, a few small-scale projects in select places, where community health workers were trained and deployed. In the beginning, as discussed in earlier chapters, LHWs often struggled to explain who they were and even faced difficulties in gaining entry into the households. This was a formidable challenge especially for the pioneer cohorts when they initially ventured into the community to introduce themselves.

*I entered a bungalow that was under construction during my field visit. I was confused, as there were so many people sitting on the ground. I sat there and those around me started asking questions. I told them I would treat minor ailments; give some medicine and weigh the children. They all started laughing and asked, "Are you a doctor or what?" I said, "I am not a doctor, but a Lady Health Worker". They started laughing again because they did not understand what I was talking about!*

*(RY, 37, LHW peri-rural, 1998)*

Over the years however, as a result of their socialisation within their communities, the LHWs were able to create a place for themselves as well-established health workers. Households in their catchment population knew and recognised them as health functionaries due to their work. Initially, women who ventured out of their homes to become LHWs were naïve and inexperienced. They did not possess any understanding of health matters or their own environs. Almost all the LHWs transformed since joining the NP, although it took them some time to achieve the conviction and identity of health workers, as Nasreen noted:

*Whatever one does become one's profession. As health workers, our identity in our communities is now that of Lady Health Worker.*

*(NA, 51, LHW rural, 1996)*

Some LHWs asserted that it took them relatively little time to acquire the persona of “LHW”. One woman, who was interested in reading medical literature and aspired to become a doctor, felt like a health worker from the initial days of training. Many sensed a change in themselves at the end of their mandatory training, while others were influenced by their entry into the field, holding their kit bags and registers, at the doorsteps of households. There were many LHWs who reported that it took years to attain the feeling of being an LHW. This was contrary to the view of the LHWs’ trainers, who thought that initial classroom training sufficed for a woman to adopt this new role.

*In my opinion, after the initial three months’ training was over, the LHWs had the ability to take forward the motto of their programme. This was despite the fact that many months of training still remained. But I think the three-month training enables them to commence their work as LHWs.*

*(NG, District Manager)*

Many LHWs started feeling like health workers after being deployed in their communities, but in many cases, it took a while to reach this stage.

*I did not feel like an LHW in the beginning, not right away. Only after a long time two or three years but even now there is still an on going change. It takes a while to gain maturity, knowing your work and realising how others think.*

*(SK, 41, LHW peri-urban 1998)*

Some LHWs stated that they developed feelings of being an LHW following some specific incident or achievement. These turning points included helping their clients pursue better health via immunisation, safe delivery or treatment. The successful outcomes of their referrals also enabled LHWs to reach this realisation. The following narrative describes how one woman’s contribution during the course of her work shaped her sense that she had indeed become a health worker.

*I felt for the first time that I was an LHW when I helped the people in my community. I accompanied a pregnant woman to the hospital, even though I*

*had no idea what would happen there. After that, I used to facilitate delivery cases and take them directly to hospital emergency. I felt happy by helping women in their difficult time. They received good treatment and their lives were saved. On the monthly vaccination days, almost seventy to seventy-five children were immunised in my health house. Although I was busy and it was a hectic day, helping children and pregnant women gave me a feeling of being an LHW.*

*(RY, 37, LHW peri-rural, 1998)*

At the outset of the NP and in the formative years of LHWs, a stereotype image of a “health worker” was being portrayed in the national media. This was of a woman wearing a white *dopatta*<sup>10</sup> with *shalwar kemis*<sup>11</sup>. However, this image was not followed as such in the field, nor did it play any significant role in the LHWs’ development of identity as health workers in their communities.

### **8.3 LHWs identity as family planning facilitators: An inherent conflict**

The NP was launched in 1994 to improve maternal and child health in Pakistan. The initial name of the programme was the “*Prime Minister’s Programme for Primary Health Care and Family Planning*”. One of the key functions of this initiative was to promote and strengthen family planning services in the country by increasing access of eligible couples to contraceptives. The LHWs were strategically well placed to help facilitate these services at the household and community levels. When they commenced their field work, straightaway they were labelled as family planning functionaries. This turned out to be a double-edged sword. On the one hand, this was the main task assigned to LHWs, while on the other; it impeded their entry into households. Any medicine or vaccines the LHWs offered were rejected, and the mothers-in-laws challenged their advocacy of family planning in their households. As one LHW recalled:

*When we started giving out the medicine, there were some who refused as they believed our medicine was for family planning. We faced a lot of difficulties in advising women regarding birth spacing; convincing both mothers and mothers-in-law was an uphill task as they were not aware about these things.*

*(AK, 50, LHW rural, 1995)*

---

<sup>10</sup> A shawl essential for women in the local context

<sup>11</sup> South Asian women’s costume, consisting of a tunic and trousers

It was difficult enough for LHWs to create their own place in their communities. Their roles as family planners made this even more challenging.

*Some people were wary of our visits. There is an old woman...whenever I visited her, she would say smilingly, but in a weird way, "I always dread your visit". Her son was her only child and she desired a big family for him. This went on like this for some time, but I tolerated these unpleasant incidents because I had to gradually create my own place within households.*

*(NA, 51, LHW rural, 1996)*

Similar issues were commonly faced by the LHWs in early days of the NP. Although their mandate included a strong component of family planning, yet many LHWs tried to disassociate this from other health-related tasks by raising awareness about general health of the community. Others tried to downplay their identity as family planners by emphasising their broader image as health workers. Incidentally another dilemma at that juncture being faced by the LHWs in the communities was polio immunisation, as communities also associated this with family planning. This was challenging, as LHWs could not distance themselves from family planning forever, nor keep aloof from polio work. They chose a middle ground and focused on raising community awareness regarding polio in an effort to alleviate the community's fears.

While LHWs were being identified in their communities as family planning workers, which in fact they were, they faced another predicament. All health workers were supposed to display a standard "Health House Board" outside their homes. Many of the LHWs' families openly opposed this, and even the LHWs themselves were reluctant to display their identity outside their homes as this highlighted their family planning role publicly.

*In the beginning, one of the biggest problems was that people didn't want to display the Health House Board outside their homes as this clearly stated the LHWs were associated with family planning.*

*(NA, National Program Manager)*

Therefore, ever since they started their work, LHWs were recognised and identified as being strongly linked with family planning. Their identity as “family planning workers” prevailed for quite some time in the communities, and still continues to some extent. Over the years LHWs themselves, however, strived to shun this identity and to avoid this label as best as they could.

#### **8.4 Recognition as a *Baji***

After serving their communities for the last two decades, LHWs felt they had become prominent in their communities due to their role as health workers. “*Baji*” is an Urdu word used for sister and can also be used for any female older than oneself, with whom one is on good terms. The community used *Baji* as an umbrella term for the LHWs and at times a qualifier was added based on their specific tasks. The households in the community also recognised LHWs by name and a few also called them as “doctor”. However, the majority addressed LHWs as *Baji* following the community norms, out of respect. As LHWs are involved in some specific tasks e.g. growth monitoring, therefore, many called them “*Wazan Wali Baji*” (*Baji* who weighs), while others used term like “*Qatron Wali Baji*” (*Baji* who gives polio drops), especially children who were their primary clients.

*NA: Our identity/recognition is because of health. [yeses and nods by all the other]*

*AS: People knew us already, but now they recognise us for all the health-related things we do.*

*NA: I have been working for the last four years and my recognition is due to health. I come across children who sometimes call me “Polio Wali Baji” or “Medicine Wali Baji, or Doctor Baji” as my recognition is through healthcare activities.*

*(FGD, LHWs peri-urban)*

An LHS described the changes she had observed over the years, in the way the LHWs were recognised by their communities.

*With the passage of time, the identity and recognition of health workers in the community has changed. Initially they were called Hospital or Centre Wali Baji. Some said Lady Health Workers or Workers, but few called them LHW.*



*Some called them by their names or as Baji who goes to hospital. In recent years after numerous polio campaigns she is called Qatron Wali Baji. However, we discourage people from calling her anything other than 'Lady Health Worker'.*

*(AB, LHW Supervisor)*

The LHWs have been involved with polio immunisation campaign since 1995. Initially, the National Immunisation Days (NIDs) were conducted twice a year, but during the last decade, as the country neared eradication of polio, the vaccination campaigns were much more frequent. LHWs are considered the backbone of polio eradication efforts in Pakistan and have spent proportionately a lot of time on this single task. The increased frequency of polio campaigns and the LHWs' intense involvement in this activity has resulted in their being labelled as polio workers. They are increasingly visible to communities due to the nature of this work as they visit door to door for conducting polio immunization.

*AB: Our identity is due to our work.*

*FQ: For children, our recognition is due to polio, and they can recognize us from distance as polio workers*

*TB: When people see us, they enquire if we have come for administering polio drops. We inform them that we have come to weigh children and give some information. However, in their minds, we only come for the polio drops. The reason being, nowadays there are so many polio campaigns.*

*(FGD, LHWs rural)*

One LHV who has worked with the NP since the beginning acknowledged the LHWs' polio eradication efforts. She feared, however, that, the LHWs' activities had been confined to polio campaigns, which was because they could hardly devote any time to maternal and child health. This was the reason the majority in the community identified the LHWs mainly as polio workers.

*I do not understand why, but the LHWs' role and work in polio campaigns has become their identity. LHWs are now mostly recognised by the community*

*through provision of polio drops. It is also possible the LHWs only visit their area for polio vaccination, and do not visit routinely in the field?*

*(BS, LHV)*

Over the years the intensive involvement of LHWs in polio activities, as also discussed in the previous chapter, has confined the LHWs from being more holistic health workers to an identity that is much more confined to a single role.

### **8.5 Recognition as doctors**

Although the community gave them different names, LHWs were recognised there, and in the health centres, due to their health related work. For this reason, there was also a tendency to call them “doctors”. LHWs seemed reluctant to accept this title, despite the community’s persistence here.

*My community does not consider me a doctor, and I correct them if they call me by that title. If we thought we were doctors, would we go from house to house? We would rather sit and treat the people!*

*(SL, 38, LHW peri-rural, 2009)*

The health managers considered the LHWs to be an extension of their district’s health network, with specific roles and responsibilities, and not to be considered and identified as freelance health practitioners.

*LHWs have established their position in their communities, which recognises them as health points of contact for households. They are government-approved health officials and are focal points with designated health houses. They have the “government’s patronage”. The community perceives them as a government approved “facilitator” for healthcare, but they are not supposed to pose or work as healthcare practitioners.*

*(ND, District Manager)*

On the other hand, the LHSs believed that LHWs were positioned in their own communities as health workers and they themselves did not try to portray as health practitioners.

*These women think of themselves as LHWs and not as anything higher than this!*

*(AB, LHW Supervisor)*

When identified as doctors, many LHWs tried to explain that they were just like other women in their community, except being more knowledgeable. The people in the community nonetheless continued to call the LHWs doctors, even though they refused to consider themselves as such.

*TP: We are not considered doctors in our communities. [muffled laughter followed by no, no]*

*AW: We are not doctors but some people in my community say, “Doctor Sahib”.*

*GB: There are few people... [Oh no!]*

*FB: When someone calls me a doctor, I inform them that our work is to provide basic information about how one can prevent disease and our work is not diagnosis and treatment. Being doctor is a bigger thing.*

*(FGD, LHWs rural)*

People often considered LHWs as an alternative to a doctor, however, and sought advice from them. The LHWs took this as a mark of respect, but they stressed that they never intentionally posed as or considered themselves to be doctors. Nasreen remarked that people call her “Doctor” as a nickname because she can give injections, take their temperature and check their blood pressure. Most of the LHWs shared the following views expressed by an experienced LHW.

*Sometimes people visit my health house to see the “doctor”. Often my father-in-law corrects them that I am an LHW. We do not consider ourselves doctors, as we do not possess the education or experience of a doctor, we are only Matric. We are afraid of giving injections, while doctors have no such fear.*

*(FA, 52, LHW peri-urban, 1995)*

The majority of LHWs shared this hesitancy to portray themselves as doctors in their communities. The health staff and district managers, however, did not fully endorse

this self-perception. Some health staff believed that the LHWs were, in fact, posing as health practitioners in their catchment areas.

*Most of the elderly people call the LHWs by name and younger ones call them Baji. Now clients come to our RHC and inform us we have been sent by this and that doctor. Yesterday a patient informed my LHV colleague that she had been sent by a doctor, who in fact was an LHW. I have heard that many LHWs do practice, give injections and perform deliveries and there are rumours that some girls even perform abortions!*

(BS, LHV)

*The LHWs during training were considered as non-technical staff and were not supposed to be raised beyond this point. However, in the field, they are like doctors. I recently attended a meeting in which LHWs, LHS, LHV and the doctor participated. One client entered the room and inquired about one of the LHW. I asked, "Why do you want to see her?" and she remarked that the LHW was their doctor. The LHW concerned smiled and said, "Madam, in my area I am viewed as a doctor".*

(NA, National Program Manager)

There was a difference of opinion between LHWs and the health managers and health centre staff regarding their identity as doctors in their communities. Nonetheless being directly involved in health related tasks, the community did identify them as a health practitioner or a sort of quasi doctor.

## **8.6 LHWs status and positioning within health centres**

The LHWs had been working within the district health system for the last two decades. At the launch of the NP, LHWs were envisaged as a bridge between the health centres and the communities, as they lived and worked in their catchment areas. During their training, LHWs were encouraged to present themselves as agents of change in their communities. According to the health centre staff, they tried to portray as such but ended up as health workers, failing to create their envisioned place in their communities as representatives of communities. As the LHWs had been selected from their communities and attached to their respective health centres, they were bound to maintain connections with both, but they often found it hard to strike a balance. However, since the beginning, many LHWs considered themselves to be the middle point between the community and the health centre, since they were members of each.

At the health centre, however, LHWs felt they were different from the rest of the staff. As far as government policy is concerned, LHWs are part of the health centres as members of staff and whatever work they are assigned is in this capacity. The community also looked at LHWs as employees of the health centres, due to their attachment to them and their health-related tasks. However, although LHWs belong to the district health system, they were still not considered on par with the other health functionaries. Over the years health care staff and health managers reached their own conclusions regarding LHWs' positioning within the health system. An LHS posted in a BHU for the last fifteen years shared her conflicting perspectives about the LHWs' sense of belonging to the health centres.

*Earlier, the LHWs did not consider themselves as part of health centres, but since they have been informed they are being made regular employees, things are different. Our relations were more with the community, as in the past, the health centre staff treated the NP as a separate entity. [I feel] it would have been better had we been part of the health centre, and worked in conjunction with the rest of the staff.*

*(SH, LHW Supervisor)*

Another LHS working with the NP since its inception expressed similar views regarding her own status as part of NP within the health centre.

*I come to the health centre for duty and consider myself part of the health centre, whether they like it or not, as we are part of the health centre! I cannot cite a specific example, but I have heard time and again that we do not have any connection whatsoever with this health centre. They claim that this health centre has nothing to do with the NP.*

*(AB, LHW Supervisor)*

The LHWs were recruited, trained and deployed in the communities by the health centre. However, even after two decades of service, some LHWs still felt removed from these institutions. A wide gap was observed between the LHWs and the health centre. According to Sughra, for example, the NP was a completely separate entity.

*We have minimal contact with the health centre as we are a separate department!*

*(SU, 41, LHW peri-urban, 1996)*

One LHS surmised that not being mainstreamed into the health centres despite their long contribution in its health activities affected LHWs' affiliation to their BHUs.

*The health centre officials do not consider LHWs as part of their team. I cannot understand why! However, the LHWs still carry a huge burden of work for the health department. Since LHWs visit the health centre for one or two days [a week] and spend the rest of the time in their community, only a few LHWs consider themselves to be part of the health centre.*

*(SH, LHW Supervisor)*

All LHWs had been attached to health centres and working in liaison with these institutions for quite a while. Most of them had decades of interaction with the staff deputed in their respective health centre. As a result, few LHWs did feel being closer to the health centre than to their community. Their experiences varied from centre to centre, however, as depicted in two contrasting narratives about an RHC and a BHU.

*We are also employees and we come regularly, at least the senior person on the staff and her assistants should not treat us like peons or servants. This is the way they deal with us and this is not acceptable. We feel [insulted] when they say, 'Why you are sitting here; leave this place! Go to your class and with whose permission did you open the door' etc. This [kind of treatment] should not take place, but I have experienced and observed this in the RHC. When we come to submit our monthly reports, an LHW is subordinate to all the staff members.*

*(ZA, 43, LHW peri-urban, 1996)*

*This BHU is like our home, as we get training and medicines from here. If we are not in contact with them, how can we be successful? And this is our base. If the BHU were not there, we could not do anything.*

*(SP, 38, LHW rural, 1999)*

The LHWs and even some health managers observed a relationship deficit between the former and the health centre staff. One senior manager perceived a need to bring LHWs into the fold of the health centres, alluding to their lack of integration in the past. The health centre staff, on the other hand, often did not accept that the LHWs

belonged to their institution i.e. health centre. According to many LHWs, they did not receive the attention they needed in their health centres. The LHSs, acknowledges this affected the relationships between LHWs and the health centre.

*Well, the LHW and health centre connection is there to some extent. LHWs visit the health centre regularly for attending monthly meetings and even otherwise. This RHC is so busy that there is hardly time to scratch one's head, let alone build relationships. However, this kind of link was never there in the true sense and is even missing now. The support from the RHC can be judged from the fact there was no designated focal person for forty LHWs who they can contact in case of need! You can say the NP is only surviving on the basis of the LHWs themselves rather than on any links to the RHC.*

*(AB, LHW Supervisor)*

The health centres were training centres and follow-up hubs for LHWs working in a union council; however, according to the LHWs, the support they received often did not meet their expectations. The health centre staff's main focus was on the LHWs' accomplishing assigned tasks. This general feeling of neglect was widespread and LHWs consequently turned to their LHS for support. Contrary to the LHWs' perceptions, most of the health centre staff considered themselves very supportive of the LHWs.

According to one doctor, the lack of interactions and relationships between LHWs and health centre staff stemmed from the RHCs' heavy workload and the LHWs' personal attitude, which culminated in their isolation in the health centre. However, there was a strong reaction when LHWs were asked if they considered themselves to be a part of the health centre. The LHWs voiced their concerns regarding their positioning based on their personal experiences.

*RK: If there is a problem or there is work to be done, we are considered part of the RHC, and if there is a problem in the community, then we are considered part of the community!!*

*YA: The staff members insult us and talk rudely. They should be careful about this. The patients we send to the healthcare centre ask us if this is the kind of respect we get.*

*RK: We do not feel like coming here. Instead of giving preference to our patients, we are asked to wait at the end of the line and the dispenser gives medicines as if he is doing us a favour. During our [health centre] visit, instead of discussing our problems, they keep criticising our work, saying, "Should we pay you for this? Do you deserve to get paid?" There is no respect for us at all, especially in our own department. Once we asked our district officer in charge about our overdue salary. He said, "You ask too many questions, if I want I can expel each and every girl!" How can anyone work without money for five months? We have a house to manage!"*

*(FGD, LHWs peri-urban)*

An LHS lamented that, after all these years of valuable service, the LHWs were still not considered to be part of the health centres.

*No one in the health centre gives them importance. If the staff wants to, only then will they listen to the LHWs, otherwise they do not get a response from the health centre the way they should. It has been like this from the start. The LHWs have always been there, but the staff never owned them. If there are no LHWs, what is the connection between the community and the health centres? Just now I told the doctor about a measles case found by the LHW working in my area. How will this kind of information reach the doctors sitting in the health centre?*

*(AB, LHW Supervisor)*

The LHWs openly expressed their dismay at being treated unfairly at the health centre, sharing their distressing experiences, even of verbal abuse. The LHWs from different centres shared similar incidents of staff neglect and discrimination. Compared to other staff members, the respect and attention they received had reportedly declined over the years. The alienation and poor treatment were a matter of concern to the LHWs as in times of need their services were warranted, but when they faced problems in the field, they were considered belonging to the community. The LHWs perceived the health centre staff considered themselves to be superior due to which they treated the LHWs unfairly. The LHWs' position in the overall hierarchy had always been low, as one manager who had been working in the NP since its inception observed.



*The LHW are placed low in the health centre hierarchy and basically, they are considered equivalent to class four employees,<sup>12</sup> who in turn consider LHWs even beneath them due to their permanent public-sector employee status. Despite knowing otherwise, the employees still consider the LHWs inferior and treat them as such.*

*(NG, District Manager)*

Some LHWs, however, thought their position would change in the future following their impending regularization as permanent employees of the health department. Nasreen, who joined in 1996, was critical of the lack of integration and ownership of health workers in the district health system. When recalling her past experiences and future expectations, she had following to say:

*They used to say [in the past], the NP, with its twenty-six LHWs and one LHS and the BHU, is like a separate family. Well now as we are becoming permanent, things are going to change. Now the health centre people are going to be our superiors and will own us.*

*(NA, 51, LHW rural, 1996)*

This statement points to the further changes LHWs expect to follow in wake of the change in their identity and status from contractual to regular employees. This issue will be discussed in detail in the next section.

### **8.7. The struggle for a new identity: Legitimising LHWs as government employees**

In the study area, the first batch of LHWs was inducted as contractual employees in 1995. Subsequently, different phases of LHWs were hired on the same terms and conditions. Initially, the contractual arrangements were acceptable to the LHWs. A few years ago, however, the LHWs initiated efforts for the regularisation of their services and to become permanent employees of the health department. Their basic premise was that they had been in service as contractual employees for such a long period of time, they deserved to be regularised. Having contributed positively for decades, they felt the matter of their regularisation was legitimate and long overdue. They wanted a change in their identity in order to achieve better status and moreover,

---

<sup>12</sup> Lowest cadre in service hierarchy

becoming eligible for long-term benefits and job security. Khalida voiced her opinion that LHWs have spent so much time on the job and deserved to be regularised.

*We have been working for so long and still have not been made permanent. We should be made permanent as we have spent more than eighteen years as LHWs roaming in the villages. Another thing comes to our minds; we are getting old and our age is such that we need future pension benefits.*

*(KA, 54, LHW rural, 1995)*

The LHWs argued there was a past precedent of the government's regularisation of contract employees, and justified their struggle for their permanent status on this premise. After serving their communities for so many years, Nasreen expressed her disappointment when the LHWs' legitimate demands were disregarded.

*If someone is on a government contract, the person will stay as such for two to three years, after which he will be made permanent. They do not think about remuneration of LHWs. They think health workers have no needs. She only has to advise other people, but should forget about her own needs and requirements. No one cares whether her needs are being met or not, especially those that can only be met after an LHW becomes permanent!*

*(NA, 51, LHW rural, 1996)*

The two main arguments given in support of their demands for regularisation included the length of their service and their useful contribution to the communities. The LHWs advocated that they should be regularised as an acknowledgment of their community work and its visible, positive impact, again attributing most of the changes in the country's health status to their own efforts. The LHWs were of the view that the regularisation of their services would further improve the performance of existing LHWs and would attract better qualified women for the job in future. They also felt that their regularisation would be mutually beneficial both for them and the health centres. The LHWs recognised the need and utility of having a health worker in their communities. They consequently felt they should be made permanent, not because of their own desires, but because of the needs of health centres and their communities. Many LHWs perceived that nobody took them seriously, and that the current efforts for their regularisation could only be credited to their own struggle and initiative.

*We always try to work honestly and to the best of our ability, so that we can meet the needs of our community. We are trying to say our work is important too, but the department will only regularise us because of their own need. They will know our worth when nobody will cooperate in polio campaigns and no one will carry out house to house visits for dengue prevention. When LHWs do not visit for a month or two in the community, the population increase will be visible, only then they will feel the need for the LHWs! Just imagine the situation eighteen years ago... the same will happen again.*

*(RK, 35, LHW peri-urban, 2007)*

This pivotal role of the LHWs was seemingly appreciated by a wider circle of stakeholders, giving impetus to their regularisation efforts. According to Nasreen:

*The health worker's job is a mainstay, like the backbone. The international people like WHO have accepted us; we think we deserve to be regularised and made a part of health department.*

*(NA, 51, LHW rural, 1996)*

In light of the foregoing context a few years ago, the LHWs initiated a struggle for the regularisation of their services. According to them, the watershed was the news about the disbandment of the LHWs at the end of December 2015. At that juncture, the LHWs opted nationally for a “*dharna*,” or sit-in, to bring their plight into the spotlight. The LHWs joined forces countrywide; amid fears that the NP was being ended and that they would be “kicked out” of their jobs and sent home. The issue of their regularisation was still before the Supreme Court of Pakistan, however. Initially the *dharnas* were in Punjab and other parts of the country, followed by big sit-ins in Islamabad. On one occasion, the LHWs protested for three days in front of the National Parliament. There were regular processions countrywide, but the main focus was Islamabad city. The LHWs held several demonstrations to build pressure for their demands. According to the LHWs who took part, these protest marches were dealt with a firm hand by law enforcement agencies.

*AW: Working in BHU was fine. We have now gone as far as the President House!*

*FB: Our representatives went...*

*AW: This time there was no baton charge*

*TB: Previously the girls were beaten and were in bad shape, and if this did not happen, we would not have achieved izzat [earned respect] or granted permanent status*

*AW: We are happy that we are making ourselves heard right to the top*

*AB: We deserve to be treated with respect and have some status; we should be allowed to feel secure in our jobs, without injustice. [Yeses and nods]*

*(FGD, LHWs rural)*

LHWs from all over the country participated in these demonstrations, including LHWs from the study area. The LHS coordinated with LHWs at the facility level and all of the LHWs joined the protest as directed by her. Police took action against them, and one or two LHWs from other provinces were injured and had to be evacuated in an ambulance. At that time, the LHWs were very apprehensive about whether their demands would ever be met.

*Our LHSs and all our LHWs were advised to seek help from the Chief Justice. We attended the dharnas [sit-ins] two or three times and went to the Supreme Court of the Chief Justice of Pakistan. LHWs from throughout Pakistan attended these protests. In these dharnas, LHSs from many areas made speeches. There were a lot of other activities. It was a good experience and [we expect that] after these activities, we would be regularised, though there are confusions about it, but still...*

*(SA, 41, LHW peri-rural, 1998)*

The demonstrating LHWs threatened that if their demands were not met, they would boycott the forthcoming polio immunisation. Most of the LHWs who participated in the *dharnas* spent the whole day marching and endured many difficulties. There were two reasons for these demonstrations, the immediate one being to boycott polio vaccination campaigns. The second was the demand for changing the LHWs' status.

*I attended the procession held in Islamabad for regularisation. I think LHWs should be regularised as the LHWs have been serving the programme for a long time. In the procession, however, we remained at the back; some in the front were beaten by police. Our experience was good as we listened to what the people were saying. The LHWs said they would not administer polio drops, nor celebrate MCH week, and we will refuse to work!*

(SZ, 36, LHW rural, 1999)

The LHWs continued their protests and staged a huge sit-in right in the heart of country's capital. The president of Pakistan issued an order for their regularisation, but the government did not accept this forthwith. The LHWs stood firm, however; they were not willing to budge from their position and refused to work for the existing salary package. The LHWs believed that, although their demands faced a lot of resistance, these were ultimately accepted because of their own activism.

*All: Are we being given the scale happily? No. [Not at all] [Laughter]*

*FB: No way...*

*TB: You know, we suffered a lot of physical violence before they decided to give us the fifth scale.*

*AW: They did not want it at all, but were also hard-pressed... Even now they do not really accept it from their heart.*

(FGD, LHWs rural)

Earlier, the LHWs had filed a case regarding their low salaries with the Chief Justice of Pakistan, which had been reviewed favourably, and their salaries were raised after an intervention by the Chief Justice. Therefore, in addition to the sit-ins and processions, the LHWs were also fighting a legal battle in the Supreme Court, hoping for a decision in their favour.

*The Chief Justice has increased our salary to seven thousand. He observed and remarked that the menial house-workers earn nine thousand to ten thousand rupees, and you only pay the LHWs a meagre sum of three thousand, and ask them to work like animals.*

(YA, 46, LHW peri-urban, 1998)

According to the LHWs, the Supreme Court facilitated their regularisation against the wishes of the health department. The LHWs were sceptical of the latter's role. They believed they only stood a chance with the Supreme Court, not the health department, as departmental policy did not favour their regularisation. The LHWs also stated that they did not have any expectations from their district health office in this regard, as in the past; the latter did not facilitate them. Instead, even at this crucial juncture, the health staff still questioned the very existence of the LHWs; neither favouring an increase in their remuneration nor regularisation of their services.

*When the NP was launched, it was decided that LHWs would not become regular government employees or be considered as such. They were not considered as facility-based or regular employees. With the passage of time, they became a large force and their demands were somehow politicised. They launched a countrywide protest, and the government could not sustain the pressure, and gave in to their demands. Now, we are hearing that a proper summary is being signed for this purpose by the prime minister. Now, everything needs to be rescheduled. The whole system would require major change, where are they going to report and sign attendance etc.?*

*(ND, District Manager)*

The LHWs explained that they were being regularised by the decision of Supreme Court, where the judges' opinion was in their favour. The LHWs consequently had great expectations of the Chief Justice.

*RK: We are receiving news of LHWs' regularisation orders, which are being issued because of the Chief Justice; however, things have not changed on ground.*

*SA: The case has not progressed.*

*RB: Now we will go to court on the Chief Justice's orders and they will expel a few LHWs and the rest will become regular.*

*RK: Even if one LHW dies, then the demands will be accepted. That is what happened in the past*

*PA: We will go to the Chief Justice again if needed*

*QN: He has done what he could do. Now it's the governments turn.*

*SA: The government will be charged with contempt of the court if they do not do obey the Supreme Court's orders.*

*(FGD, LHWs peri-urban)*

The LHWs were also wary of the health department's disapproval of the whole regularisation process, contrary to the orders of the Chief Justice of Supreme Court, even though the health department was bound to implement court verdicts.

*When this issue of regularisation came up, contrary to the judiciary and the Chief Justice, those on the side of the government were not in favour. The government resisted strongly, saying such a huge budget was not possible, and also that the NP was not worth it. But once the judiciary's ruling was issued from the Supreme Court, it had to be implemented. This outcome was totally unexpected; it was just an incidental or accidental happening. Starting from pay release, it moved forward to end at the regularisation of the LHWs. The LHWs were able to work things to their advantage, and the movement gradually gained momentum. I shouldn't be saying this, but the conflict between the government and the judiciary went in the LHW's favour.*

*(FT, National Program Manager)*

Health centre staff and health managers considered the regularisation of the LHWs' services to be unnecessary. One pioneer manager who had played a pivotal role in NP activities at the district and national level explicitly opposed their move into government service.

*If the LHWs are regularised, the NP will lose its initiative. The LHWs will be protected as civil servants, being a regular government cadre. The main reason for the success of the NP was the health workers' contractual status. Their daily working time is supposed to be only two to four hours. To deploy a regular government employee for this task, who cannot be easily terminated, is not wise. Now I am afraid that the LHWs will lose their work momentum in their communities.*

*(MZ, National Programme Manager)*

At the health centre level, even the female LHVs had their qualms about regularising LHWs. A LHV closely associated with the LHWs since 1995 felt that this decision was a waste of resources.

*I do not see any benefit from regularisation of the LHWs, as it is only a burden on the government, for example, as we have nineteen LHWs. There will be expenses on them while we do not perform deliveries as we lack staff like midwives and needed funds.*

*(BS, LHV)*

One LHS gained a similar impression from health centre staff:

*The health staff has a mixed reaction, as mostly they think that, after regularisation, the LHWs will get sluggish. They will not work efficiently, although a few feel they will work better. However, most of the people I came across are not happy. The health centre staff from the very beginning has not given LHWs any importance. When and where they are needed, they accept them; otherwise the general impression was the LHWs are good for nothing. They just keep on sitting around and still get salaries.*

*(AB, LHW Supervisor)*

The LHW had been working for almost two decades, but the health department did not want or think they would ever become regular employees, always assuming that the NP would finish in a few years' time. These sentiments were expressed so often that the LHWs knew their regularisation was not favoured by the department. The health centre staff also questioned the logic behind the health department's regularisation, as Mehtab remarked.

*I do not know whether the department is happy or not. However, I have come to know they say that LHWs should not have been made permanent.*

*(MB, 52, LHW rural, 1996)*

The LHWs came across criticism of their regularisation by the health centre staff, which made them sombre. When the LHWs encountered health department staff, they could sense that many did not seem comfortable with the decision to regularise their services.



*The health department should be happy on our regularisation. As we are from the same field and work for them, they should think good for us. They say now, we're equal, and I fail to understand this. Some say it in a good way, while others break our hearts.*

*(AI, 36, LHW peri-urban, 2007)*

Some members of the staff in the health department were openly opposed to this change.

*When we were campaigning, some people were not in favour. I do not understand the reasons. Some people still question this, why and how this happened. Even some doctors think like this and they say, we were not compensated for our hard work, why have the LHWs been made permanent and given a scale, and some doctors have said this in my presence. The community does not care whether we are part of health centres or not; they are more concerned with their own access. It is the centre staff that reacts both positively and negatively. If a person says, we have nothing to do with the national programme, why complain about regularisation now?*

*(ZA, 43, LHW peri-urban 1996)*

The sentiments of the staff were not confined to a few individuals or places, and seemed to be relatively widespread. Some members of the staff in health department openly disapproved the LHWs' regularisation. For some individuals, the LHWs' low level of education was the reason they disagreed with their being given a permanent status. Said Nasreen:

*One person repeats time and again that "uneducated women" are being regularised. When LHWs were recruited, middle class was the criteria. We worked for last eighteen years in field, and there are government employees who are not even middle, like gardeners, who are permanent.*

*(NA, 51, LHW rural, 1996)*

Some health managers were more pragmatic in their analysis of the regularisation of LHWs.

*There is quite a mixed reaction if you consider the ground reality, the programmes, e.g. dengue, polio... all realise they cannot mobilise communities without LHWs. These campaigns are being done through the*

*LHWs. Therefore, some appreciate them a lot, while others complain that they do not possess enough qualifications, so there is a bit of friction, which has encroached upon the NP. Some lower staff being better qualified than the LHWs, but are working in lower grades do show some concern.*

*(FT, National Program Manager)*

### **8.8 There's many a slip 'twixt the cup and the lip: Apprehensions on regularisation**

When this study was being conducted decision regarding LHWs regularisation was on the anvil in the Supreme Court. The government was in the process of regularising services, but the LHWs were still very apprehensive. Their primary concern was that, if they had been regularised, why had they not received their revised salaries etc.? Although many LHWs believed they were being regularised, they still expressed doubts about the actual implementation of this process. These doubts and apprehensions were common in LHW narratives. One concern several women shared was that if they were not ultimately regularised, as was their right, the majority would quit their jobs.

The LHWs started off as contractual employees receiving just a stipend, without any long-term benefits; the monthly stipend was 1,200 rupees. As contractual employees, the LHWs dreaded the pay stoppages and job insecurity. One LHS believed that, because LHWs in her area worked as contractual employees, they often compromised on the quality of their work.

*They used to go to the field as contractual employees, but were persistently careless. They wanted to finish all visits in an area on the same day, even if it there were fifteen houses; the policy of five houses a day was seldom followed. Being regular now, they have confidence that their job is permanent and feel secure that they cannot be expelled. Still, I do not foresee any change in their status in the community though.*

*(SH, LHW Supervisor)*

Despite the impression, shared by some, that LHWs would be less motivated after the regularisation of their services, this move has actually rejuvenated their spirit. An

LHS who has worked with LHWs for the last two decades observed:

*Well, the health centre staff still cynically says, “Now you are regular”. I don’t think anyone has accepted this decision wholeheartedly, like it should have been. LHWs are putting in their best effort; they are improving their health houses. They have bought white Chaddar<sup>13</sup> and move about in their communities carrying their new kit bags displaying the NP monogram. They are re-registering households and visiting communities. There is a visible positive change after regularisation of services.*

*(AB, LHW Supervisor)*

The LHWs expected after regularisation their pay would increase while their duties and responsibilities would stay the same. They felt that regularisation would enhance their social as well as financial status, thus enabling them to invest in their family’s well-being. The LHWs received a stipend, but, as they were contract employees, the amount was fixed. However, after regularisation, LHWs were to be placed on an official basic pay scale, something that comes with regular government service. The LHWs believed that being granted a “scale” was important as this reflected a change in their status in the government hierarchy. The LHWs also expected being in a basic pay scale like other government employees they would be eligible for medical benefits and an annual salary increase. The LHWs considered the potential granting of the scale a landmark step in their careers, and they were happy that their standing in the health centres would improve.

*Our supervisor said that you people are now in a scale and you are no less than anyone else. Now you can take a stand when someone scolds you or asks you to do odd jobs, as we have been adopted by the government as staff.*

*(ZU, 42, LHW peri-urban, 1999)*

In light of the above, the LHWs envisaged working with more interest. The LHWs were of the view that a rise in salary would be beneficial in countering the objections raised from their household members, even if they had to work in health facilities. Their overall status and identity will change in light of these changes.

---

<sup>13</sup> A cloth used as a head covering (and veil and shawl)

There were pros and cons of regularisation, as stated by the LHWs. The LHWs felt that since regularisation had been announced, they were being treated a lot more strictly. In the last two or three months, they reported a noticeable change in the attitude of those in charge at the health centres, as well as their field supervisors, who stressed that the LHWs had to work hard in the prescribed manner. They had not had a kit bag for the last fifteen years, for example. Now their managers directed them to carry their kit bag with them. With impending regularisation, the LHWs had observed a sudden increase in the attention paid to their punctuality and work schedule.

One of their big concerns during the transition phase was about potential changes to their work routine. The LHWs were worried that, in future, they would have to sign in at the health centre every day, before proceeding to fieldwork. Currently they visited households at their convenience, and they were apprehensive that this change would mean that they would no longer have the flexibility to schedule their work around their household responsibilities. Many LHWs thought that, the change in their status would draw them closer to the health centre. If they were supposed to sign regular attendance they would be in daily contact with their health centre, otherwise they would continue with the old routine. A change was perceived in the supervision of the LHWs after regularisation, however.

*We were being supervised in the field, but now there is a little more strictness. Nowadays, officials visit door to door for checking; in the past they did not visit households. I think this is because of the regularisation! There was supervision, but now there is a little more than before and we are told they will be issuing warning letters to LHWs who do not work. This is from the National Programme, as no one from the centre visits to check us.*

*(RP, 47, LHW rural, 1996)*

There was consensus on stronger supervision amongst the district health managers. This meant that LHWs with less than satisfactory performance records could be terminated.

*We have decided that we will strengthen our supervision, and the evaluation would be performance-based, which might lead to termination of those who do not perform. Earlier we thought they had a meagre pay, even if they were doing the bare minimum, it was acceptable, as we thought their presence was enough and they could be used in the event of an emergency. But this cannot continue anymore, especially in the absence of tangible benefits.*

*(FT, National Program Manager)*

In the RHCs included in this study, LHWs were already assigned static duties inside the health centres. The LHWs were anxious they would be more involved in the health centre's static activities and their assigned work would increase. Considering themselves a part of the health centre after becoming regular employees, the LHWs were worried that they would have to do whatever duty they were assigned. A few viewed the regularisation of LHWs as an advantage for the health centres, as these would now be able to benefit more from their work, especially in terms of facility-based services.

LHWs like Nasreen were mostly very optimistic about the forthcoming change in their job status.

*Once permanent, the LHWs would feel on the moon! Their salary will be so much better. I am under Matric and if they are making me permanent and giving me a salary and pension on retirement, what else can I wish for? We have spent a difficult time and borne a lot of difficulties, and it is high time to reap the reward.*

*(NA, 51, LHW rural, 1996)*

The LHWs saw a bright future and expected a great deal of improvement after regularisation. Most of them thought they would work with more enthusiasm, and looked forward to when they received their enhanced remuneration. According to the supervisors, the LHWs' status in their own households would also change for the better in future.

*In some cases, LHWs were told to leave their job, or their household members advised them to quit, criticising it. Now they are permanent and their pay will increase and their mothers-in-law will not say, why you go outside the house*

*every day, but will be supportive. Knowing that the LHW will bring money to her son's home, their attitude will undergo a positive change.*

*(SH, LHW Supervisor)*

According to the LHWs, this decision would positively impact women aspiring to become LHWs, as Nasreen says.

*There are many types of people. The educated girls or teachers look down upon us as we go door to door. Since we are regular now, BA and MA girls say Baji, we want to become LHWs. Now even for LHWs, there would be lot of competition. When we joined, no one was ready to become an LHW and now even an MA girl requests to be hired as an LHW. The LHWs have a bright future in front of them.*

*(NA, 51, LHW rural, 1996)*

According to the LHV, women in the community are approaching them and are looking for ways to get into the NP as LHWs.

*Women with BAs are coming and requesting us to induct them as LHWs. Some girls with MAs and BAs are married to less educated men who do not work. The parents marry their sons and when they want to live independently, the parents ask them to manage their household. Then girls start looking for jobs, and this is big change, as in the past, women were not allowed to work as LHWs.*

*(NJ, LHV)*

The children of the LHWs who joined in the initial cohorts are mostly adults now. Some have finished their education and now express their reservations regarding their mothers' work, citing various reasons, e.g. low salaries, long working hours during polio immunization campaigns and their mothers' health issues. Some appreciated their mother's work and also supported her efforts. However, a few wanted their mothers to quit their jobs now that there was no longer any *majboori*. These adult children did not approve of their mothers going from house to house, considering it, like many adult male family members, to contravene social norms. This was reflected in the feelings of Nasreen's son.

*My children ask me to quit the job, since my son is able to support me now. "You go from house to house. This is not right." My eldest son is influenced by what people think. He asks me to quit as he can contribute the amount I receive as a salary towards the household. "You have worked enough." I said, "Son, I can leave other things, but not this!"*

*(NA, 51, LHW rural, 1996)*

It is interesting to see that the overall scenario has changed and conflicting views on entry as LHWs persist and a whole circle has been covered.

## **8.9 Conclusions**

When the LHWs were first introduced their communities were not aware who they were or what they would do. The health workers were trained at the health centres and commenced work in their communities. These were lay women to start with but due to socialising with the households in their communities they were gradually recognised. They performed various tasks and developed their identity around their work practices. There was an evolutionary process initially labelled as family planning workers, being a negative connotation in their conservative patriarchal communities. However, over the years, there has been a shift based on their tasks such as immunization and growth monitoring. Their current identity is strongly related to polio, due to their visibility and deep involvement in polio immunisation efforts. As a mark of respect they were mostly called as "Baji" a term used with their task as a qualifier. Since LHWs are related to health, people at times in some places identify them as doctors, and some LHWs allegedly indulge in curative work true to this nomenclature.

The LHWs have been working for the last two decades in their communities. They have been in close interaction with the health centre staff during mandatory training and thereafter. They work in liaison with the health centre staff and LHSs. The position of the LHWs in the centre and their ownership by the health centre staff however, remained a weak link. This is another example of the situational ownership of the LHWs within the district health system. This effected socialisation of the

LHWs within the district health system and development of their identity as health workers and integration within health centres.

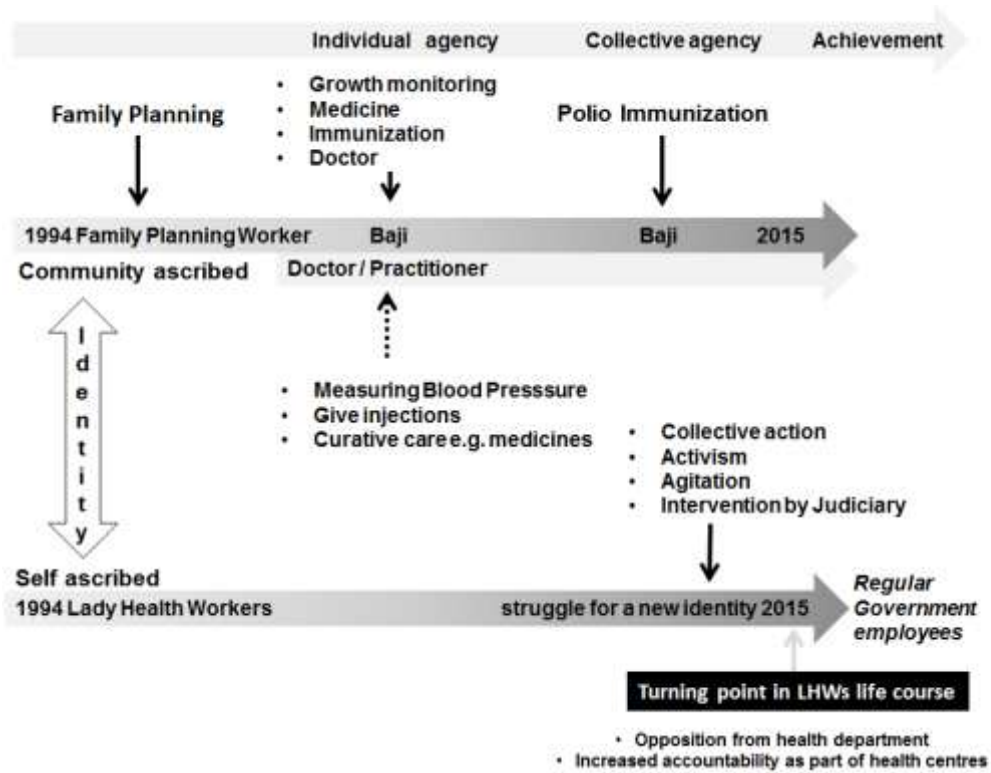
The positioning of the LHWs in the health centres is reflective of the gaps in integration of LHWs in the district health system. The LHWs were rather better placed in their own communities. The LHWs on their end considered themselves to be part of the mainstream health system. This recognition was being not reciprocated by the health centre staff. To gain an identity and status in the mainstream district health system the LHWs therefore, initiated their own struggle for regularisation. This was also reflective of their collective agency resulting in activism for regularisation of their services. With the grant of this regular status the LHWs expected becoming part of the health centres. This included the grant of government “scale” a symbol which will provide them with a new identity and moreover, legitimise their position in the health system on par with other government employees. It is promising for the LHWs, but not necessarily to the liking of the health department.

The LHWs have been working for almost two decades. In their case they perceive that the biggest turning point is their conversion from contractual to regular employees of government with the status of civil servants. In the wake of their being made a regular part of the health department, staff there are fears about the future reorganisation of the department. It seems the *laissez-faire* relationship will also change, as the health department’s ownership of the LHWs will increase. Another case of situational ownership this will include an increase in the supervision and accountability of LHWs. Their new identities as regular government employees will also result in their being embedded in the health centres, just like other members of the health centre staff.

The journey of LHWs in development of their identity is shown in Fig.No 8.1 below. The way the health system and the LHWs identify themselves based on their experiences. The community links their identity to their tasks. This is based on the socialization process of the LHWs and their work practices.

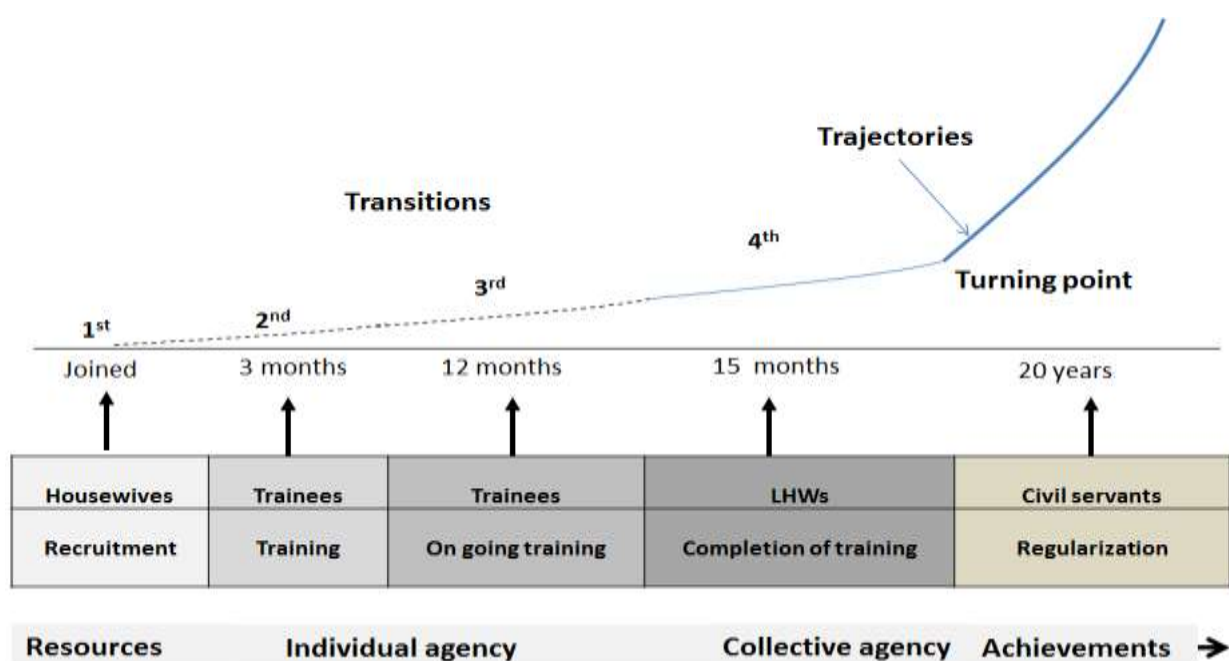


**Fig.8.1. Evolution of the LHW identity**



The LHWs underwent many changes after joining as the NP overtime from housewives to an identity and status regular civil servants as shown in Fig. 8.2. The LHWs passes through different phases and through their efforts were able to create a space in the district health system in two decades as health workers.

**Fig. 8.2 LHWs life trajectories path towards an identity**



The next chapter a discussion based on the results and analysis is presented in light of the issues being debated in literature.

# Chapter IX

## Discussion

### 9.1 Introduction

The LHWs are the pioneer community-based health workers of their kind in Pakistan. Their journey can be traced back to 1995, when the National Programme was launched, with all the political expediency and backing of the Prime Minister. The statement that the LHWs have come a long way since then' is not a rhetoric statement anymore. This study traces the journey of the LHWs by taking into account their own perspective as well as that of other significant stakeholders such as managers and health care professionals of varying cadres. It explores the ways these women have developed over time, in response to their life and work experiences, ultimately leading to their defined personhood or identity. It also seeks to gain a better understanding of how the dyad of the community and the formal health care system has influenced the professional contribution of this cadre of health workers.

### 9.2 Primary Motivation for the LHW

Even though an extremely heterogeneous workforce, coming from a variety of backgrounds, education statuses and initial life experience, it was striking to note that the main impetus to join the National Programme was verbalised as “Majboori” (financial need). This blanket term masked a myriad of underlying causes, from husband's unemployment to abject poverty. As women with limited years of education, the LHWs did not have many options to choose from in a society delineated by patriarchal norms. While on one hand their female gender helped them enter this profession, on the other it was a major impediment, for these women needed permission from their male head of family before being recruited, despite being eligible for the post. This permission took some persuading, especially for the pioneer cohort, due to lack of credible evidence of having such a workforce in place.

This Majboori was not only significant in bringing potential candidates forward for recruitment despite the absence of precedence, it also mellowed down the resistance of significant others in the family, so that they were willing to permit their women to

join the NP as LHW, against the prevailing gender norms. It was the same Majboori which kept the LHW going, even though she faced resistance from within her family as well as the community and faced challenging times when her stipend was delayed for months on end due to administrative reasons. Often the stipend was the only source of income for the LHWs' family (Khan, 2011b). These challenges have been voiced by similar research perspectives of LHWs published earlier (Afsar and Younus, 2005). A review of literature revealed that women in rural areas considered becoming an LHW as an opportunity or a chance to empower themselves socially, personally and financially (Willis-Shattuck et al., 2008).

### **9.3 Transitions and Turning Points**

Among the several frameworks I use to unpack the LHWs point of view, the life course perspective (Elder et al., 2003) offers many advantages. The three dimensions of this framework, namely turning point, transition and trajectories (George, 2003) can be aptly applied to the professional journey of the LHW. Taking the first step of becoming the LHW was itself a huge turning point in the life course of the LHW, for this strategic life decision reflected a big leap of faith on her part. She was expected to navigate two vastly different domains, both unfamiliar and outside her normal circle of influence (Abbatt, 2005). One of these was her community, where she belonged but had limited contact with outside family friends and extended family, and the other was the health centre which she had hardly visited prior to her recruitment. Using Kabeer's (Kabeer, 1999) interpretation, it was agency which led the LHW to pursue a career involving door to door visits and engaging with the health centre, even though the prevailing norms favoured opposition of both activities, in the form of gendered segregation, limited female mobility outside home and dominance of male decision-making. As a first step towards empowerment (Khan, 2008), the LHWs demonstrated a keen desire to help their communities on one hand (*khidmat ka jazba*) and to upgrade the status of their own families through the stipend, even though it was not considered substantial enough to meet all their needs.

As described in the results chapters, many significant events were recorded in the lives of women opting to become LHWs. These transitions within the LHWs can be traced back to landmark events. Four such distinct events encountered by LHWs

included the decision to join as an LHW, formal training, venturing into communities on their own in their new role as LHW and completion of required fifteen months training.

#### **9.4 Transformation through Professional Socialisation**

Research on socialisation of individuals working in the health sector like doctor, nurses (Serra, 2008) and other allied health professionals has struggled to define their professional socialisation, because of its nonconformity to traditional socialisation (Kalmus, 2006). Professional socialisation has been defined in many ways, but typically it is considered a process comprising three stages which are anticipatory, formal and working career and practice (Miller, 2010). In the case of doctors and nurses these three distinct phases of socialisation are apparent (Price, 2009). However, for LHWs, the professional socialisation was found to be different as the anticipatory phase existing in most other health professions was noticeably missing. When first introduced in Pakistan, the LHWs were not a recognized cadre (Khan, 2008), therefore, the first phase was formal socialisation commenced after taking up the role of LHW. The phase of formal socialisation involved undergoing training and commencing work in their communities. In case of LHWs they underwent a rigorous, standardised training, followed by household visits and registration of households in their catchment areas (Bhutta et al., 2008).

Most of the professionals in the health sector work in institutions like hospitals or clinics, in anticipation of joining a profession. These professionals are better informed and have made up their mind on their observations or experiences. They are then socialised in their institutions and undergo academic training, are imparted skills in a controlled environment which is specifically designed for this purpose (Kalmus, 2006). During this phase they socialise with others of their kind e.g. nurses or teachers representing their profession (Sutherland et al., 2010, Serra, 2008). In contrast, the socialisation of LHWs occurred in a different setting. Right after induction, they were deputed in a health centre to undergo formal training. Thereafter, their socialisation occurred in their own communities during the course of their fieldwork. As in the case of other CHWs (Knettel et al., 2017), the LHWs also encountered power and educational differentials during training as they interacted with more qualified health

centre staff. The process of socialisation of LHWs can be appreciated in four distinct phases; initial contact with health care facility, during training, at initial contact with the community and still on-going while provision of services to the members of the community. Thus socialisation process of LHWs differed from facility based health workers as the major share of time was spent on the household visits (Afsar and Younus, 2005). The LHWs were therefore, socialised on two vastly different fronts i.e. health centres and their community.

Once the LHWs formally entered the system, their process of socialisation was influenced by multiple interactions with individuals in the community and health centre, as well as the tasks they were supposed to perform. Some of these tasks were part of their normal job description, however others could be counted as task shifting or use of LHWs as a makeshift arrangement (Smith et al., 2014). There were several limitations to these interactions, both at the community as well as the health centre, many of which related to gender and will be discussed in a later section. The whole process was multipronged in nature, due to the involvement of multiple locales, namely the LHW's health house, community households and the health centre. To some extent the process of socialisation preceded the formation of identity, however both processes continued simultaneously, parallel to each other, throughout the professional life of the LHWs. As an on-going process, this socialisation contributed towards the formation of LHW identity as skilled health worker.

## **9.5 Gender aspects of a gendered workforce**

Gender is all the more important as most of the CHWs around the globe are female. In case of LHWs, gender had been intertwined in all aspects of their lives, right from the start of their careers. The case of LHWs is unique as they were meant to serve as a channel to enhance women's access to health services and thus reduce gender differentials in health (Rizvi et al., 2014). Due to gender issues recruitment of women as LHWs had to be carefully thought out and was quite difficult (Shepard, 2016).

Gender and the overall organisation of their community played a major role in the LHW's socialisation. For the LHWs, gender cuts across all spheres of personal and professional lives (Mumtaz et al., 2003a), a context by no means unique to Pakistan,

as societies in Africa also face similar issues (Porter, 2011). Other studies have also recounted the hesitancy of the LHWs to communicate or engage with male community members (Haq and Hafeez, 2009). Gender differentials were a major barrier in making the male health committee functional (Mumtaz et al., 2003a). Due to restrictions on male health centre staff's community visits, they could not contribute either. However, even the women's health committees were also not functional, which means that there were other factors at play.

The formal health system also displayed a gender bias, which affected the female community health workers performance adversely. In health centres major interaction of the LHWs occurred with female staff as the NP policy had delineated the male and female divide. The female staff was supposed to be LHWs direct in-charges. Therefore, the LHV (health centre) or LHSs (field) were the key people with whom the LHWs regularly interacted with, enjoying better relationships with the LHSs as compared with LHVs. The LHSs were designated to supervise LHWs in their communities while the health centre staff had no time to spare for such activities. Although gender differentials did not exist within the female health staff such as LHV or female doctors at the health centre level, but still there was a big gap between the LHWs and health centre staff due to power differentials.

Whether it was intra-household division of labour or mobility outside the house, most things were governed by gender norms and not in favour of the female LHW in the patriarchal social system (Ferdoos and Zahra, 2016). In the community, only women and children could be accessed by the LHW, for health advice as well as for health committee formation, while the men were out of bounds due to constraints of gender segregation. Similar gender segregation existed at the health centre, in addition to hierarchical issues concerning centre staff. The LHWs also had to surmount these challenges in a culture (Mumtaz et al., 2003b).

## **9.6 Gendered barriers**

The LHWs were introduced to improve access of the women to the health services in Pakistan. The access issues were related with the availability or existence of health services. In addition social factors emanating from the patriarchal norms of the

communities also posed issues (Scott et al., 2010). There were restrictions on women around segregation, mobility and gender based divisions of labour. These gender based barriers were encountered in full force by the NP when the recruitment of LHWs was initiated (Mumtaz et al., 2003b). The NP apart from the expectation of LHWs to work against the prevailing gender norms was in line with the gender norms of the patriarchal culture. This was reflected at various levels. At the household level the permission for the LHWs to work was granted by the head of the family. The interaction with the community was to be confined to the men and even at the health centre level the LHWs had to be trained, supervised and encouraged to keep liaison with the female staff (Bhattacharyya et al., 2001). Their interaction with the men outside their homes in any sphere was cursory. The NP evolved in the communities as a gendered entity and workforce has been established. The overall context remains patriarchal in the health centres and district health system. This has implications on the organisational setup and at times leads to conflict in case of NP and LHWs integration and other management issues.

Provision of social support has been considered a crucial element in CHW-mediated health gain (Taylor et al., 2017). Even after years have passed, the LHWs could recount the initial difficulties, and the way they had to negotiate their entry into the households even though their interaction in the households was confined only to women. Better support for the LHWs has been advocated earlier as well (Closser and Jooma, 2013). Thus, it took a lot of effort and self efficacy i.e. agency (Kabeer, 1999) on part of the LHW to enter the established health care system and use all the available resources in order to make a living for her family and serve the community in the process. Regardless of the fact that gender impinges on all on-going parallel processes of socialisation and identity formation, the LHWs have been able to create a niche for themselves to survive in their microcosm.

### **9.7 Forging a new Identity over time**

All newcomers in a well-established system take time to develop their identities (Blåka and Filstad, 2007). The LHWs had been employed for quite some time and during the course of their work had developed their own identity. The professionals are socialised and subsequently develop what is referred to as their professional



identity (Adams et al., 2006). Professional identity has been studied among different professionals, but rarely among CHWs (Squires and O'Brien, 2012, Ramirez-Valles, 1998a). This is a dynamic process in which it has been recognized that identities are constructed and deconstructed as a result of interaction between the different actors (Blåka and Filstad, 2007). The LHWs seemed to have forged their own identity as a result of their socialization, by and large identifying themselves as health functionaries however; being community based there was a dissonance in their identity.

The gendered nature of the LHW's job meant that being female was a double edged sword (Smith et al., 2014). At times gender was a facilitating factor, for instance the LHWs were recruited to improve the access of the women and children to the health services available, and by virtue of being female workers, they were able to reach these women and children, and spread the message. However, their female gender was also a major obstacle in entering this profession (Miller, 2010). In conformity with the gender norms, the NP also required permission from head of household before induction. Conducting house visits in the community also clashed with the prevailing practice of restricted movement of the females outside their homes, especially unaccompanied and in unknown terrain. After becoming LHWs, these women overcame these obstacles through sheer determination and demonstrated their individual agency in the process.

The roles of the CHWs have been known to change according to the needs of the community (Malcarney et al., 2017). Even though primarily envisaged as agents of change, specific task-based recognition of CHWs may also confine their role to being service extenders (Colvin and Swartz, 2015). Due to their regular and mandatory involvement in frequent Polio eradication campaigns, the LHWs identity in their communities was increasingly linked to this special task, (Bahar et al., 2017) overshadowing the rest of the preventive services provided by them. The polio immunization days were frequently scheduled (Bahar et al., 2017), and the LHWs visibility during this activity had led to their image as "polio workers". Initially labelled as family planning worker, the LHWs had been referred to with different names over the years, aligned with the tasks they performed. At times the community

regarded them as doctors due to their health related work. This was also influenced by individual variations in skills of the LHWs as some are more skilled, having acquired selected nursing skills over time. Most of the LHWs however, had developed an identity more or less as health workers in their communities. Their identity as a LHW was forged as a result of the overall socialisation process and work practices of their job, as seen in other parts of the globe (Mpembeni et al., 2015). These women had been transformed from novice health workers to accomplished health workers, so much so that many in the community recognised them as doctors and some LHWs reportedly even pursued medical practice.

Development of the identity of Health Worker took some time, the majority reporting feeling like an LHW when they either started their training at the health centre or started their work in the field for the first time. Thus interaction with the community and with the health centre staff gradually allowed the LHWs to gain their trust, and undergo a subtle but sure transition. The extent of this change varied from individual to individual, but with the passage of time and due to concerted efforts on part of the LHWs, they were able to win the trust of the community members. However, for the majority of LHWs, the trust and respect that they enjoyed with members of their community was not easy to acquire, for the LHWs were unable to live up to all of the community's expectations (Colvin and Swartz, 2015). One such expectation was provision of curative services was not part of their job description, but demanded by the community. Maintaining this trust was also not easy, especially in the absence of a well-functioning health system and lack of support regarding referrals.

LHWs use of agency (albeit limited) led to a myriad of perceived and actual achievements. The LHWs reported enhanced public speaking skill which facilitated community engagement, confidence on tackling queries regarding health issues and financial stability. Some indirect achievements which were shared very proudly were the higher level educational attainment of the children of the LHWs. These women expressed their satisfaction on having looked after their respective families well through sharing the degrees of their children and having built a house of their own, both valuable assets in their culture. They reiterated the fact that family planning and

vaccination facilities provided by them were now sought after, a huge improvement from the time when they first started their careers, and took credit for this change.

## **9.8 Transitions**

Transitions in the LHWs' life course were thus related to their self-perceived identity, overall socialisation and practices. Everything had not been a smooth sail for the LHWs; the barriers that they had had to overcome were not limited to the community, the health system barriers were very much in their way. These barriers included lack of support regarding referral, the basic tenet of the LHWs' function as a bridge between the community and the formal health care delivery system (Hafeez et al., 2011). It has been argued that weak health systems compensate their shortcomings through a variety of the gendered workforce, including Community Health Workers (George, 2008). This seemed to hold true for LHWs in this study as well.

## **9.9 Situational ownership**

Pakistan has a vast network of public sector health facilities. One of the main arguments for introducing LHWs by the NP in Pakistan in 1994 was to establish and strengthen the referral links, considered essential for CHWs and other gendered workforce around the world (George, 2008). At that time links of the community with health centres did not exist therefore, the client referral was quite poor. One of the key tasks of CHWs is referral of clients from the communities to health centers. This vital role is according to the ILO<sup>14</sup> definition of CHWs and responsibilities delineated by the WHO to CHWs. The role of CHWs in bridging the gap between community and health centres for improved uptake of existing services is acknowledged globally (Bhattacharyya et al., 2001). Of their many roles, one task expected from the CHWs is conducting outreach services to ensure access to care (Perry et al., 2014). This is also true for the LHWs as they perform many such functions as extensions of health services in their communities.

The contribution of CHWs in immunization programmes has been acknowledged worldwide (Patel and Nowalk, 2010). Contrary to the wide gaps in referral process, the interaction between LHWs and health centre staff was very close in a few select

---

<sup>14</sup> ILO. International Standard Classification of Occupations Structure, group definitions and correspondence tables; ISCO-08, International Labour Office, Geneva. 2007.

activities. Illustrative examples were routine vaccination, special immunization initiatives against e.g. polio, measles or emergency conditions such as dengue fever epidemics.

### **9.10 Linkages and Referral**

The LHWs worked in liaison with the health centres and strived to develop links of community and health centres. A significant proportion of the LHW training focused on referrals from the community to health centres. There is consensus that once the LHWs commenced their work things did not improve as expected. Although a key function of CHWs as suggested by the various stakeholders including WHO (WHO, 2007c, WHO, 2007d, Svitone et al., 2000) was included in the mandate of LHW nonetheless, referrals handling faltered. The need for a functional referral system for CHW effectiveness has been emphasized (Winch et al., 2003, Kouyaté et al., 2008, Zachariah et al., 2007) however, in many instances like in this study area this did not materialize. In Pakistan, effectiveness of the LHW referral system within NP and district health system is questionable. It is suggested a bidirectional referral and feedback loop can improve CHW performance (Chanda et al., 2011) and effectiveness (Khan, 2011b) however, in case of NP both aforesaid dimensions remained weak. A key indicator, i.e. referral of clients did not reach the expected mark for the simple reason that one side of the referral chain was unresponsive to the clients referred by the LHWs, while they should have given the clients preferential treatment. Thus the relationship of the LHW and health centres became strained and all stakeholders suffered a setback.

Local support is central to the overall goal of workforce sustainability (Alvillar et al., 2011). The ownership of LHWs by the district health system fluctuated considerably based on the nature of needs of the health centres. CHWs are often constrained by the plurality of tasks assigned to them and the limited support they receive from the health sector (Glenton et al., 2013). In case of LHWs, they were also assigned multiple tasks. Some of these tasks were based in their own communities e.g. immunization while others such as referral were dependent on their links with the health centres. The interaction was mainly of two types, firstly being inclusive as in case of the immunization activities especially polio immunization as the LHWs were

proactively involved. The second turned out rather exclusive in case of LHWs referrals.

In activities related with immunisation, especially the polio campaigns, the LHWs were well sought after. However, in case of referrals the response according to the LHWs was very poor. The LHWs were multi tasked workers therefore; failure of their referrals adversely affected their work practices (Baker et al., 2007). The position and credibility of LHWs within their communities was compromised. The importance given to the LHW referrals by facility-based health workers also is a sign of respect given to the LHW by the health system. In case CHWs' referrals are not entertained, community may lose trust and do not seek further services from CHWs (Prasad and Muraleedharan, 2008). The failure of LHWs thus had a negative effect on their position in the communities. It has been suggested that CHWs try to achieve the best health outcomes possible in their communities despite resource constraints (Guilbert, 2006). In case of failure of the referrals, their motivation and performance was effected.

The LHWs have been working for more than two decades in Pakistan. The LHWs were recruited, trained and deployed by the health centres. In beginning the oversight and interest of the district health system was rather close. With the passage of time the health centres and district health staff lost interest in LHWs except, when they were needed for some specific task. However, following the recent regularization of LHWs there is resurgence in interest. There is a deep interest in LHWs both at the health centre and district health office levels. The LHWs are once again being drawn closer to the district health system. In past there were perceived gaps between the LHWs and health centre staff. The recent administrative changes are reflective of a selective dichotomy of ownership by the district health system including the health centres. At last the LHWs are being brought into the fold of the district health system and inching towards integration in the public sector health system.

The LHWs have been trained as a multi task worker but over the years are involved only in a few roles. The LHWs use in a few selected tasks has semblance of the selective verses comprehensive PHC debate. The LHWs from being a holistic health

worker as envisaged are being confined LHWs to one priority task i.e. polio. This also alludes to a situational ownership of the LHWs, meaning selective engagement. This has implications on their position within communities and interactions with others affecting their socialisation, as has been suggested earlier (Sutherland et al., 2010). The involvement of LHWs selectively in some activities while compromising others has its manifestations on the development of their identity as LHWs. This has led to their recent identity and public image of polio worker.

### **9.11 Individual to Collective Agency (Activism)**

The women when they joined as health workers were mostly house wives. They came from different backgrounds and also had been working in their communities. The training and interaction within the households as part of their work has brought about many changes in the LHWs (Hafeez et al., 2011). Their work practices and development of skills has transformed over the years into health workers. The individual agency has enabled them to engage and pursue their work practices. Since joining as LHWs they were contractual employees for almost two decades. In the mid-2000s, there was a change in the organisation of ministerial setup of Pakistan due to the devolution of the provincial subjects like health and education. There were fears that LHWs would be disbanded for good. Around those years the LHWs had mustered their strength and led a successful struggle for increase in their salaries.

In the last few years the LHWs also started a movement to become integral part of the health system. They struggled to shun their contractual status and strived to become regular employees of the government (Closser, 2015). They were successful in their struggle as result of Supreme Court decision despite stiff opposition by the health departments. This brought about a change in the identity and relationships of the LHWs within the health system (Afsar and Younus, 2005). Having achieved a new status and identity as permanent employees, they considered themselves as a part of health department. The regularisation of the LHWs was a landmark event as it altogether changed the identity and status of LHW almost overnight. They were no

more pawns of the health system but fully integrated within health department after this decision.

Despite being involved in individual activities using their agency in their field of work, over the years the LHWs also developed a “collective agency” (Andrae et al., 2013). This was reflected as their strength when they all rallied together and struggled for their regularisation, a watershed moment for the NP as their enhancement of their status to a regular employee which had never been on the agenda. This turn of events also caught the district health system by surprise. Among the millions of CHWs working around the globe, this type of collective rallying for legitimising their role as seen in the case of LHWs in Pakistan has no parallel.

Integrating CHWs into mainstream health care services has been termed beneficial to the community and to health care organizations (Alvillar et al., 2011). As long as LHWs were contractual they were not counted as health staff. However, after regularization the whole scenario seems to have changed as personnel in the health department felt a renewed need of disciplining the LHWs.

### **9.12 Agents versus extenders**

There has been a long on-going debate regarding the CHWs as agents or extenders under the PHC domain. The NP was launched with well-defined objectives which focused on improving maternal and child health. The focus was not on any concomitant structural change but rather on countering the access issues with provision of health care at the doorsteps of the communities (Standing and Chowdhury, 2008b). The job description and their training were also focused on their function as extenders. There were a few components of community organizations and participation in the didactic training as part of mandatory training at the start of the induction of LHWs. The socialization and work practices of the LHWs have been in various activities such as immunization, raising awareness of communities and referrals. There was a component that dealt with issues of community participation and involvement of platform of health communities which might have enabled them

to play the agents of change role (Theobald et al., 2015) but that aspect was never taken up by the NP seriously. The LHWs have been involved various activities and have a tactical advantage of being close to their communities. They have access into the households and maintain links with the health centres. This results in reducing the gender barriers of women at the household level.

### **9.13 Organizational hierarchy**

The LHWs are important and situated in the health system in health centre. They have been working in liaison with the health centres. They are placed as representatives of community in the health centre. It is interesting to examine where they lie in the overall hierarchy at three levels. They have developed a niche for themselves at the community level as health workers. They are now identified because of their health related work (Bhutta et al., 2010). In the health centres they are seen as the extensions of the health department in the communities however, where they are situated in the organizational hierarchy after all these years is questionable. The perceived idea is they belong to community and do not fit into the health centre hierarchy as such understandably, the LHWs have leaned more towards their LHSs over the years as the health centres have considered them to be a separate department. The regular employees of the health department considered themselves above the LHWs. However, with the regularization as they have been granted a salary scale the things have changed and now being considered an integral part of the health centres in future there will be many changes.

### **9.14 Recommendations for policy and practice**

The LHWs were introduced in rural areas to enhance access of health services of women and children. The study suggests that since launching of the LHWs they have spent a lot of time in communities and have developed relationships with women in households. There is evidence in this study that the initial momentum of the NP could not be maintained over the years. The relationships between LHWs and the health centre staff have become somewhat stagnant, affecting their positioning within the health system as health workers. This stagnation also impinges on the identity and



work practices of the LHWs. In many cases the LHWs end up masquerading as health workers. Therefore, the LHWs should receive ample support including logistic to enable them to achieve their full potential as health workers in the years to come, especially since they have been made permanent. There is an urgent need to revisit the NP strategy and devise an inclusive policy for adoption by all stakeholders. The LHWs as key stake holders should be part of this change process.

Despite commonalties, the various differences among LHWs must be acknowledged, for these women cannot be stereotyped as individuals. In view of the varied professional trajectories, there should be renewed focus to improve and enhance professional skills in uniform manner.

The scope of the LHWs to enhance the availability of primary, preventive, promotive and some curative care services at the doorsteps of community still remains pertinent in today's setting. Therefore, the LHWs should be viewed as an asset rather than a liability. However, as the LHWs were introduced in mid 1990s and the overall context and scenario has changed considerably, therefore, there is a need to review the role of LHWs within the health system including the communities. The health department should facilitate the LHWs in their communities and should support them in their health centres especially to enhance the referral link. The gender issues still pose a barrier however; modalities should be worked out to enable male staff to contribute in LHWs' activities in a culturally acceptable manner. The staff of health department also needs reorientation as many newly inducted health professionals have no idea of the training and supervision of the LHWs, therefore, their skills and capacity need to be built.

There have been great demographic and epidemiological changes in the area. The LHWs should be involved in NCD Prevention and care as well as implementation of Universal Health Care to the marginalized population, through health insurance schemes.

The public sector health centres are increasingly overburdened and inadequately equipped to deal with the diverse needs of this growing population. Furthermore, most

of the individuals residing in the LHWs' catchment area frequently seek treatment from private health practitioners; this state of affairs dilutes the efforts of the LHWs. Improvement is required in the quality of services provided at public sector health facilities, including supporting referrals of LHWs. In addition, modalities for liaison between LHWs and private sector may be devised, however, with caution. After their regularisation, the LHWs should be integrated into the formal health system, capitalizing their potential for organization of communities, making use of LHW bodies for further empowerment.

### **9.15 Limitations of the study**

This study was based on a constructivist approach and used self-reported data. There is a likelihood of recall bias as some of the events recounted happened decades ago. There may be selective memory and there might be an element of attribution, thereby attributing positive or negative events to internal or external forces. There might be an exaggeration or might not even be the reality when compared with other data sources. The data collected in this study is specific to the study area and therefore, not generalizable. This is not a true limitation as this study did not envisage generalizability. Being formative in nature, this research allows others to build upon the findings.

Another limitation was dearth of literature dealing specifically dealing with socialization and identity issues of the CHWs. Despite the availability of literature on motivation, performance and practices of the CHWs, the available conceptual frameworks are centered on the western context and based mostly on institutions like hospitals. Their application is also rather limited as context of the LHWs is entirely different. There was however, a need for participatory methods like observation and possible shadowing, which was not carried out. Similarly the LHWs household members and their community members were not included. Therefore, only including LHWs and a variety of health department stakeholders might not be holistic. The insights from household members and community members would have been valuable. Observing LHWs as they met in groups and shadowing them in their fieldwork could have potentially enriched the findings.

### **9.16 Contribution in knowledge**

This piece of research looks through the lens of the personal experiences of LHWs, focusing on how the socialization and practices contribute in their overall development and identity formation. This thesis provides an original body of knowledge exploring the life trajectories of LHWs along with the underlying influences. This contribution expands research on CHWs in an important area which is so far relatively under-researched. Generalisability of findings was never a purpose of the study. However, this study does contribute to a better understanding of the trajectories of LHWs and their relationship with the health system. The process of their socialization, practices and identity formation is presented based on a conceptual framework developed for this study. In terms of theory the interplay of the three constructs is vital.

The study furnishes evidence on the software issues of the LHWs e.g. relationships between LHWs and other stakeholders in the study district, an interface that needs to be explored further. Another main contribution this study offers is building upon the current literature base regarding CHWs, which can facilitate further research on LHWs. In this thesis different bodies of literature from different disciplines was used e.g. human resources in health, health systems development, psychology and sociology etc. However, this research mainly contributes to the field of health systems research, and offers useful insights which can be utilized in future policies and practices. There is very limited research on the areas covered in this study. This research is aimed at advancing understandings of personal and professional trajectories of LHWs which can be used by a variety of stakeholders.

### **9.17 Areas for further research**

More research is recommended on the socialization process of the CHWs. The focus in this study is limited to one district of one country. Replication of the research in other places in Pakistan and other countries would be beneficial for CHWs. This opens avenues for further much needed evidence focusing on personal aspects of

CHW. The key areas of research include but are not limited to the exploration of the interplay between socialization, practices and identity processes, and how these three concepts influence the motivation and retention of LHWs. There is a need to study various dimensions of CHWs and how they are situated in the social and health system at meso and micro levels.

### **9.18 Conclusion**

The purpose of my study was to look into the process of how and where the LHWs position themselves within the health system and how they have changed since their joining and acquired a new identity. This research was designed to include the perspectives of the LHW and other stakeholders including the health managers and others who came in close interaction with the LHWs. What I found was that the LHWs joined because of their needs and this was the main consideration for these women. One of the main emerging themes is situational ownership; the LHWs are not as deeply embedded in the formal health system as expected and there are ownership issues at the health centres, where the LHWs do not get the required respect. The communities in which they work are gendered, as is the health system around them, starting from their induction and permission to work, interaction with the men and how the health centres and their supervision was concerned. I found that the LHWs passed through distinct phases of induction, training and deployment in the field. These phases contributed towards the socialization process, which is still on going. Their identity emerged gradually, once they had rendered a variety of services. Over time, the LHWs have undergone substantial change and become completely different persons. Over all these years, they have tended to ally with the health sector but remained at its periphery however, after their regularization they have a feeling of belonging to health department since they started their career. The irony is that a top down initiative received permanency through a top down intervention, this time courtesy of the judiciary. This was only possible through activism of the LHWs themselves. This change will also go a long way in further mainstreaming of the LHWs in the health system.

## **Conclusion**

The purpose of my study was to look into the process of how and where the LHWs position themselves within the health system and how they have changed since their joining and acquired a new identity. This research was designed to include the perspectives of the LHW and other stakeholders including the health managers and others who came in close interaction with the LHWs. What I found was that the LHWs joined because of their needs and this was the main consideration for these women. They have transformed into new individuals as health workers. The LHWs were not as deeply embedded in the formal health system and there are ownership issues at the health centres, where the LHWs do not get the required respect. Nonetheless, they have gained confidence and play an important role in many public health initiatives. The communities in which they work are gendered, as is the health system around them, starting from their induction and permission to work, interaction with the men and how the health centres and their supervision was concerned. I found that the LHWs passed through distinct phases of induction, training and deployment in the field. These phases contributed towards the socialization process, which is still on-going. Their identity emerged gradually, once they had rendered a variety of services. Over time, the LHWs have undergone substantial change and become completely different persons. Over all these years, they have tended to ally with the health sector but remained at its periphery however, after their regularization they feel they are part of the public health sector. The irony is that a top down initiative received permanency through a top down intervention, this time courtesy of the judiciary. This was only possible through activism of the LHWs themselves. This change will also go a long way in further mainstreaming of the LHWs in the existing and future health system.

## 10. Bibliography

2010. Govt. accepts demands of lady health workers. *Express Tribune*, June 4, 2010.
- 2012a. Court asks provinces to pay salary of lady health workers today. *The New International*, August 17, 2012.
- 2012b. Government accepts demands of lady health workers *Express Tribune*.
- 2012c. SC issues notices to health secretaries over lady health workers issues. *Dawn*, April 23, 2012.
2013. LHWs regularization of job to boost outreach programme. *Pakistan News Newspaper* 22 June 2013.
2014. *Dawn*, October 24th, 2014.
- February 16, 2012. Lady health workers defy tear gas shelling, baton charge by police outside press club Karachi. *PakMed InfoForum*.
- June 4, 2010. Government accepts demands of lady health workers. *Express Tribune*.
- ABBATT, F. 2005. Scaling up health and education workers: community health workers. *London: DFID Health Systems Resource Centre*.
- ADAMS, K., HEAN, S., STURGIS, P. & CLARK, J. M. 2006. Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care*, 5, 55-68.
- AFSAR, H. A. & YOUNUS, M. 2005. Recommendations to strengthen the role of lady health workers in the national program for family planning and primary health care in Pakistan: the health worker's perspective. *J Ayub Med Coll Abbottabad*, 17.
- AFZAL, S., NAEEM, A., SHAHID, U., SYED, W. N., KHAN, U. & ZAIDI, N. M. 2016. Effective role of lady health workers in immunization of children in Pakistan. *Pakistan journal of medical sciences*, 32, 1500.
- AGARWALA, R. & LYNCH, S. M. 2006. Refining the measurement of women's autonomy: an international application of a multi-dimensional construct. *Social Forces*, 84, 2077-2098.
- AKINTOLA, O. 2010a. Perceptions of rewards among volunteer caregivers of people living with AIDS working in faith-based organizations in South Africa: a qualitative study. *Journal of the International AIDS Society*, 13, 22.
- AKINTOLA, O. 2010b. What motivates people to volunteer? The case of volunteer AIDS caregivers in faith-based organizations in KwaZulu-Natal, South Africa. *Health policy and planning*, 26, 53-62.
- ALAMO, S., WABWIRE-MANGEN, F., KENNETH, E., SUNDAY, P., LAGA, M. & COLEBUNDERS, R. L. 2012. Task-shifting to community health workers: evaluation of the performance of a peer-led model in an antiretroviral program in Uganda. *AIDS patient care and STDs*, 26, 101-107.
- ALAVI, H. 1991. Pakistani women in a changing society. *Economy and Culture in Pakistan*. Springer.
- ALVILLAR, M., QUINLAN, J., RUSH, C. H. & DUDLEY, D. J. 2011. Recommendations for developing and sustaining community health workers. *Journal of Health Care for the Poor and Underserved*, 22, 745-750.
- ANDERSON, S. & ESWARAN, M. 2009. What determines female autonomy? Evidence from Bangladesh. *Journal of Development Economics*, 90, 179-191.
- ANDRAE, G., BECKMAN, B., BROWN, A., PRAG, E., JIMU, I. M., LYONS, M., BOAMPONG, O., HANSEN, K. T., JORDHUS-LIER, D. & MITULLAH, D. W. 2013. *Africa's Informal Workers: collective agency, alliances and transnational organizing in urban Africa*, Zed Books Ltd.
- ANGEN, M. J. 2000. Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, 10, 378-395.
- ASHFORTH, B. E. & SAKS, A. M. 1995. Work-role transitions: a longitudinal examination of the Nicholson model. *Journal of Occupational & Organizational Psychology*, 68, 157-175.
- ASHFORTH, B. E., SLUSS, D. M. & HARRISON, S. H. 2007. Socialization in organizational contexts. *International Review of Industrial and Organizational Psychology*, 22, 1-70.
- BACH, R. 1998. The Gender Knot: Unraveling Our Patriarchal Legacy. *Contemporary Sociology*, 27, 241.

- BAHAR, S., KHALID, R., KHAN, S. A., NASEEMULLAH, N. & BATOOL, N. 2017. Challenges and experiences of Lady Health Workers working in Polio Campaigns in District Nowshera, Khyber Pakhtoonkhwa, Pakistan. *Pakistan Journal of Public Health*, 7, 75-78.
- BAILEY, C., BLAKE, C., SCHRIVER, M., CUBAKA, V. K., THOMAS, T. & MARTIN HILBER, A. 2016. A systematic review of supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa. *International Journal of Gynecology & Obstetrics*, 132, 117-125.
- BAKER, B., BENTON, D., FRIEDMAN, E. & RUSSELL, A. 2007. Systems support for task shifting to community health workers. *Geneva: The Global Health Alliance*.
- BAKER, E. A., BOULDIN, N., DURHAM, M., LOWELL, M. E., GONZALEZ, M., JODAITIS, N., CRUZ, L. N., TORRES, I., TORRES, M. & ADAMS, S. T. 1997. The Latino Health Advocacy Program: a collaborative lay health advisor approach. *Health Education & Behavior*, 24, 495-509.
- BALLARD, M., MADORE, A., JOHNSON, A., KEITA, Y., HAAG, E., PALAZUELOS, D. & ROSENBERG, J. 2018. Community Health Workers. *America*, 1, 35-37.
- BANDURA, A. 1977. *Social Learning Theory*, New Jersey Prentice-Hall, Englewood Cliffs.
- BANGDIWALA, S. I. 2011. Workforce Resources for Health in Developing Countries. *Public Health Reviews*, 1, 296-318.
- BARBOUR, R. 2005. Making sense of focus groups. *Medical Education*, 39, 742-750.
- BARBOUR, R. S. 1998. Mixing Qualitative Methods: Quality Assurance or Qualitative Quagmire? *Qualitative Health Research*, 8, 352-361.
- BARON, R. A. & BYRNE, D. 1997. *Social Psychology*, Boston, Allyn and Bacon.
- BATLIWALA, S. 1994. *Women's empowerment in South Asia: Concepts and practices*, Asian South Pacific Bureau of Adult Education.
- BAXTER, P. & JACK, S. 2008. Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, 13, 544-559.
- BECKER, H. S. 2002. *Boys in white: Student culture in medical school*, Transaction publishers.
- BENDER, D. & PITKIN, K. 1987. Bridging the gap: the village health workers as the cornerstone of the primary health care model. *Social Science and Medicine*, 24, 515-528.
- BENNETT, F. 1979. Primary health care and developing countries. *Social Science and Medicine*, 13, 505-514.
- BENYOUSSEF, A. & CHRISTIAN, B. 1977. Health care in developing countries. *Social Science and Medicine*, 11, 399-408.
- BERGER, P. L. & LUCKMANN, T. 1967. *The social construction of reality: a treatise in the sociology of knowledge*, Harmondsworth, Penguin Books.
- BERGER, P. L. & LUCKMANN, T. 1991. *The social construction of reality: A treatise in the sociology of knowledge*, Penguin Uk.
- BERMAN, P. A., GWATKIN, D. R. & BURGER, S. E. 1987. Community-based health workers: head start or false start towards health for all? *Social science & medicine*, 25, 443-459.
- BHASIN, K. 1993. *What is patriarchy?*, Kali for Women.
- BHATIA, K. 2014. Community health worker programs in India: a rights-based review. *Perspectives in public health*, 134, 276-282.
- BHATTACHARYYA, K., WINCH, P., LEBAN, K. & TIEN, M. 2001. Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability. Published by the Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development. *Arlington, Virginia*.
- BHUTTA, Z. A., LASSI, Z. S., PARIYO, G. & HUICHO, L. 2010. Global experience of community health workers for delivery of health related millennium development goals: a systematic review, country case studies, and recommendations for integration into national health systems. *Global Health Workforce Alliance*, 1, 61.
- BHUTTA, Z. A., MEMON, Z. A. & SOOFI, S. 2007. Implementating community based perinatal care: results from a pilot study in rural Pakistan. *Lancet (submitted)*.
- BHUTTA, Z. A., SOOFI, S. & MEMON, Z. 2008. Training for Lady Health Workers clarified. *Bulletin of the World Health Organization*, 86, B-B.

- BLACK, R. E., TAYLOR, C. E., AROLE, S., BANG, A., BHUTTA, Z. A., CHOWDHURY, A. M. R., KIRKWOOD, B. R., KURESHY, N., LANATA, C. F. & PHILLIPS, J. F. 2017. Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 8. summary and recommendations of the Expert Panel. *Journal of global health*, 7.
- BLÅKA, G. & FILSTAD, C. 2007. How does a newcomer construct identity. *A socio-cultural*.
- BLOOM, S. S., WYPIJ, D. & GUPTA, M. D. 2001. Dimensions of women's autonomy and the influence on maternal health care utilization in a north Indian city. *Demography*, 38, 67-78.
- BRAUN, R., CATALANI, C., WIMBUSH, J. & ISRAELSKI, D. 2013. Community health workers and mobile technology: a systematic review of the literature. *PloS one*, 8, e65772.
- BREAKWELL, G. M. 2006. *Research methods in psychology* London, Sage Publications.
- BROWN, J. S. & DUGUID, P. 1998. Organizing Knowledge. *California Management Review*, 40, 90-111.
- BRYANT, J. 1969. Health and the developing world. *Health and the developing world*.
- BURR, V. 2003. Social constructivism. *London and New York: Routledge*.
- CAIRNS, R. B. & RODKIN, P. C. 1998. Phenomena regained: From configurations to pathways.
- CAMPBELL, C., GIBBS, A., NAIR, Y. & MAIMANE, S. 2009. Frustrated potential, false promise or complicated possibilities? Empowerment and participation amongst female health volunteers in South Africa. *Journal of Health Management*, 11, 315-336.
- CAMPBELL, C. & SCOTT, K. 2011. Retreat from Alma Ata? The WHO's report on Task Shifting to community health workers for AIDS care in poor countries. *Global public health*, 6, 125-138.
- CAREY, M. A. 1994. *The group effect in focus groups: Planning, implementing, and interpreting focus group research*, Thousand Oaks, CA, Sage.
- CAREY, M. A. & SMITH, M. 1994. Capturing the group effect in focus groups: a special concern in analysis. *Qualitative Health Research*, 4, 123-127.
- CARR, W. 2006. Philosophy, methodology and action research. *Journal of Philosophy of Education*, 40, 421-435.
- CARTER, S. M. & LITTLE, M. 2007. Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, 17, 1316-1328.
- CHANDA, P., HAMAINZA, B., MOONGA, H. B., CHALWE, V. & PAGNONI, F. 2011. Community case management of malaria using ACT and RDT in two districts in Zambia: achieving high adherence to test results using community health workers. *Malaria Journal*, 10, 158.
- CHEN, L., EVANS, D., EVANS, T., SADANA, R., STILWELL, B., TRAVIS, P., VAN LERBERGHE, W. & ZURN, P. 2006. The world health report 2006: working together for health. *Geneva: World Health Organization*.
- CHEN, L., EVANS, T., ANAND, S., BOUFFORD, J. I., BROWN, H., CHOWDHURY, M., CUETO, M., DARE, L., DUSSAULT, G. & ELZINGA, G. 2004. Human resources for health: overcoming the crisis. *The Lancet*, 364, 1984-1990.
- CLOSSER, S. 2015. Pakistan's lady health worker labor movement and the moral economy of heroism. *Annals of Anthropological Practice*, 39, 16-28.
- CLOSSER, S. & JOOMA, R. 2013. Why we must provide better support for Pakistan's female frontline health workers. *PLoS medicine*, 10, e1001528.
- COHEN, H. A. 1981a. *The nurse's quest for a professional identity*, Addison-Wesley.
- COHEN, H. A. 1981b. *The nurses quest for a professional identity*, Menlo Park, CA, Addison-Wesley.
- COHEN, L., MANION, L. & MORRISON, K. 2013. *Research methods in education*, Routledge.
- COLVIN, C. J. & SWARTZ, A. 2015. Extension agents or agents of change? *Annals of Anthropological Practice*, 39, 29-41.
- CONWAY, M. E. 1984. Socialization and roles in nursing. *Annual review of nursing research*. Springer.



- COYNE, I. T. 1997. Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, 26, 623-630.
- CRESWELL, J. W. & CRESWELL, J. D. 2017. *Research design: Qualitative, quantitative, and mixed methods approaches*, Sage publications.
- CRESWELL, J. W. & MILLER, D. L. 2000. Determining validity in qualitative inquiry.
- CRITELLI, F. M. 2012. Voices of resistance: Seeking shelter services in Pakistan. *Violence against women*, 18, 437-458.
- CROTTY, M. 1998. *The foundations of social research: Meaning and perspective in the research process*, Sage.
- CUETO, M. 2004. The origins of primary health care and selective primary health care. *American Journal of Public Health*, 94, 1864-1874.
- DANIELS, K., VAN ZYL H, H., CLARKE, M., DICK, J. & JOHANSSON, E. 2005. Ear to the ground: listening to farm dwellers talk about the experience of becoming lay health workers. *Health Policy*, 73, 92-103.
- DAVIS, A. J. 1969. Self-concept, occupational role expectations, and occupational choice in nursing and social work. *Nursing research*.
- DE REGT, M. 2007. *Pioneers or Pawns? Women Health Workers and the Politics of Development in Yemen* New York Syracuse University Press.
- DENZIN, N. K. & LINCOLN, Y. S. 2011. *The Sage handbook of qualitative research*, Sage.
- DICICCO-BLOOM, B. & CRABTREE, B. F. 2006. The qualitative research interview. *Medical Education*, 40, 314-321.
- DIELEMAN, M. & HARNMEIJER, J. W. 2006. Improving health worker performance: in search of promising practices. *Geneva: World Health Organization*, 5-34.
- DOHERTY, T. M. & COETZEE, M. 2005. Community Health Workers and Professional Nurses: Defining the Roles and Understanding the Relationships. *Public Health Nursing*, 22, 360-365.
- DOMBECK, M. 2003. Work narratives: gender and race in professional personhood. *Research in Nursing & Health*, 26, 351-365.
- DONALDSON, J. H., MCCALLUM, J. & LAFFERTY, P. 2010. Can we predict successful completion of the common foundation programme at interview? *Nurse Education Today*, 30, 649-656.
- DONNAN, H. 1997. *Family and gender in Pakistan*, New Delhi, Hindustan Publishing Corporation.
- DOSS, C. R. 1996. Testing among models of intrahousehold resource allocation. *World Development*, 24, 1597-1609.
- DRAPER, A. & SWIFT, J. A. 2011. Qualitative research in nutrition and dietetics: data collection issues. *Journal of Human Nutrition and Dietetics*, 24, 3-12.
- DUGGLEBY, W. 2005. What about focus group interaction data? *Qualitative Health Research*, 15, 832-840.
- DUNCAN, S. 1991. The geography of gender divisions of labour in Britain. *Transactions of the Institute of British Geographers*, 420-439.
- EDGE, J. & RICHARDS, K. 1998. Why best practice is not good enough. *Tesol Quarterly*, 32, 569-576.
- EISENHARDT, K. M. 1989. Building theories from case study research. *Academy of Management Review*, 14, 532-550.
- ELDER, G. H., JOHNSON, M. K. & CROSNOE, R. 2003. The emergence and development of life course theory. *Handbook of the life course*. Springer.
- ELLIS, F. 1993. *Peasant economics: Farm households in agrarian development*, Cambridge University Press.
- ENG, E. & YOUNG, R. 1992. Lay health advisors as community change agents. *Family & Community Health: The Journal of Health Promotion & Maintenance*.
- ENGELS, F. 2010. *The origin of the family, private property and the state*, Penguin UK.
- ETIKAN, I., MUSA, S. A. & ALKASSIM, R. S. 2016. Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, 5, 1-4.
- FADE, S. A. 2003. Communicating and judging the quality of qualitative research: the need for a new language. *Journal of Human Nutrition and Dietetics*, 16, 139-149.
- FARQUHAR, S. A., WIGGINS, N., MICHAEL, Y. L., LUHR, G., JORDAN, J. & LOPEZ, A. 2008. "Sitting in different chairs:" roles of the community health workers in the Poder es Salud/Power for Health Project. *Education for Health*, 21, 39.

- FAUZIAH, R., NAEEM, A. I., LEAH, S., BEENISH, M., AYSHA, Z., KASHIF, S., WAFA, A., SHAGUFTA, P. & AHMAD, Q. S. 2016. Challenges in implementing a community based trial in a rural Pakistani district: lessons learnt from project NIGRAAN. *Health Systems and Policy Research*, 3.
- FELDMAN, D. C. 1981. The multiple socialization of organization members. *Academy of management review*, 6, 309-318.
- FERDOOS, A. & ZAHRA, S. 2016. Patriarchy and Decision Making Power of Women. *Journal of Gender & Social Issues*, 15.
- FERN, E. F. 1982. The use of focus groups for idea generation: the effects of group size, acquaintanceship, and moderator on response quantity and quality. *Journal Of Marketing Research*, 19, 1-13.
- FERNÁNDEZ, R. 2007. Alfred Marshall Lecture; Women, Work and Culture. *Journal of the European Economic Association*, 5, 305-332.
- FIELDING, N. 1994. Varieties of research interviews. *Nurse Researcher*, 1, 4-13.
- FIKREE, F. F. & PASHA, O. 2004. Role of gender in health disparity: the South Asian context. *British Medical Journal*, 328.
- FINANCE, M. O. 2016-17. Economic Survey of Pakistan.
- FISHER, C. D. 1985. Social support and adjustment to work: A longitudinal study. *Journal of Management*, 11, 39-53.
- FISHER, C. D. 1986. Organizational socialization: an integrative review. *Research in Personnel and Human Resources Management*, 4, 101-145.
- FLICK, U. 2009. *The sage qualitative research kit: Collection*, SAGE Publications Limited.
- FRANCO, L. M., BENNETT, S. & KANFER, R. 2002. Health sector reform and public sector health worker motivation: a conceptual framework. *Social science & medicine*, 54, 1255-1266.
- FRANKEL, S. & DOGGETT, M.-A. 1992. *The community health worker: effective programmes for developing countries*, Oxford University Press, USA.
- FREDRICKS, K., DINH, H., KUSI, M., YOGAL, C., KARMACHARYA, B. M., BURKE, T. F. & NELSON, B. D. 2017. Community health workers and disasters: lessons learned from the 2015 earthquake in Nepal. *Prehospital and disaster medicine*, 32, 604-609.
- FREEMAN, T. 2006. 'Best practice' in focus group research: making sense of different views. *Journal of Advanced Nursing*, 56, 491-497.
- FRENCH, S. E., WATTERS, D. & MATTHEWS, D. R. 1994. Nursing as a career choice for women in Pakistan. *Journal of Advanced Nursing*, 19, 140-151.
- FRYMUS, D., KOK, M., DE KONING, K. & QUAIN, E. 2013. Knowledge gaps and a need based Global Research agenda by 2015. *Global Health Work Alliance Report*.
- GABITOVA, G. & BURKE, N. J. 2014. Improving healthcare empowerment through breast cancer patient navigation: a mixed methods evaluation in a safety-net setting. *BMC Health Serv Res*, 14, 407.
- GEARING, R. E. 2004. Bracketing in Research: A Typology. *Qualitative Health Research*, 14, 1429-1452.
- GECAS, V. 1982. "The self-concept." *Annual Review of Sociology*, 8, 1-33.
- GEE, J. P. 2005. The new literacy studies: From socially situated to the work. *Situated literacies: Reading and writing in context*, 2, 177-194.
- GEORGE, A. 2008. Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems *Global Public Health*, 3, 75-89.
- GEORGE, L. K. 2003. Life course research. *Handbook of the life course*. Springer.
- GHUMAN, S. J., LEE, H. J. & SMITH, H. L. 2006. Measurement of women's autonomy according to women and their husbands: Results from five Asian countries. *Social Science Research*, 35, 1-28.
- GIDDENS, A. 1984. *The constitution of society: Outline of the theory of structuration*, Univ of California Press.
- GILSON, L. 2003. Trust and the development of health care as a social institution. *Social science & medicine*, 56, 1453-1468.
- GILSON, L., WALT, G., HEGGENHOUGEN, K., OWUOR-OMONDI, L., PERERA, M., ROSS, D. & SALAZAR, L. 1989. National community health worker programs: how can they be strengthened? *Journal of public health policy*, 10, 518-532.
- GLENTON, C., COLVIN, C. J., CARLSEN, B., SWARTZ, A., LEWIN, S., NOYES, J. & RASHIDIAN, A. 2013. Barriers and facilitators to the implementation of lay health

- worker programmes to improve access to maternal and child health: qualitative evidence synthesis. *Cochrane Database Syst Rev*, 10.
- GLENTON, C., SCHEEL, I. B., PRADHAN, S., LEWIN, S., HODGINS, S. & SHRESTHA, V. 2010. The female community health volunteer programme in Nepal: decision makers' perceptions of volunteerism, payment and other incentives. *Social science & medicine*, 70, 1920-1927.
- GOPALAN, S. S., MOHANTY, S. & DAS, A. 2012. Assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. *Bmj Open*, 2, e001557.
- GORDON, M. 2009. Toward a pragmatic discourse of constructivism: Reflections on lessons from practice. *Educational studies*, 45, 39-58.
- GOVERNMENT OF PAKISTAN 2006. Annual Report. In: HEALTH, M. O. (ed.). Islamabad.
- GOVERNMENT OF PAKISTAN 2007. Internal Assessment of Lady Health Worker Programme. In: HEALTH, M. O. (ed.). Islamabad.
- GREENSPAN, J. A., MCMAHON, S. A., CHEBET, J. J., MPUNGA, M., URASSA, D. P. & WINCH, P. J. 2013. Sources of community health worker motivation: a qualitative study in Morogoro Region, Tanzania. *Human resources for health*, 11, 52.
- GREGG, M. F. & MAGILVY, J. K. 2001. Professional identity of Japanese nurses: bonding into nursing. *Nursing and Health Sciences*, 3, 47-55.
- GRIX, J. 2010. *The foundations of research*, Palgrave Macmillan.
- GUBA, E. G. & LINCOLN, Y. S. 1994. Competing paradigms in qualitative research. *Handbook of qualitative research*, 2, 105.
- GUILBERT, J. 2006. The World Health Report 2006: working together for health. *Education for health (Abingdon, England)*, 19, 385.
- HADLEY, M. & MAHER, D. 2000. Community involvement in tuberculosis control: lessons from other health care programmes. *The International Journal of Tuberculosis and Lung Disease*, 4, 401-408.
- HAFEEZ, A., MOHAMUD, B. K., SHIEKH, M. R., SHAH, S. A. I. & JOOMA, R. 2011. Lady health workers programme in Pakistan: challenges, achievements and the way forward. *JPMA. The Journal Of The Pakistan Medical Association*, 61, 210-215.
- HAINES, A., SANDERS, D., LEHMANN, U., ROWE, A. K., LAWN, J. E., JAN, S., WALKER, D. G. & BHUTTA, Z. 2007a. Achieving child survival goals: potential contribution of community health workers. *The Lancet*, 369, 2121-2131.
- HAINES, A., SANDERS, D., LEHMANN, U., ROWE, A. K., LAWN, J. E., JAN, S., WALKER, D. J. & BHUTTA, Z. A. 2007b. Achieving child survival goals: potential contribution of community health workers. *Lancet*, 369, 2121-2131.
- HALIMAN, A. & WILLIAMS, G. 1983. Can people move bureaucratic mountains? Developing primary health care in rural Indonesia *Social Science and Medicine*, 17, 1449-1455
- HALL, D. T. 1987. Careers and Socialization. *Journal of Management*, 13, 301.
- HALL, S. & SAKAI, N. 1998. A Tokyo dialogue on Marxism, identity formation and cultural studies. *Trajectories: Inter-Asia Cultural Studies*, 360-78.
- HANDLEY, K., CLARK, T., FINCHAM, R. & STURDY, A. 2007. Researching Situated Learning. *Management Learning*, 38, 173-191.
- HAQ, Z. & HAFEEZ, A. 2009. Knowledge and communication needs assessment of community health workers in a developing country: a qualitative study. *Human resources for health*, 7, 59.
- HAQ, Z., IQBAL, Z. & RAHMAN, A. 2008. Job stress among community health workers: a multi-method study from Pakistan. *International journal of mental health systems*, 2, 15.
- HARDING, S. G. 1987. *Feminism and methodology: Social science issues*, Indiana University Press.
- HEALTH, M. O. 1996. Prime Ministers Programme For Family Planning And Primary Health Care. In: CARE, P. M. P. F. F. P. A. P. H. (ed.).
- HEALTH., M. O. 1993. National Health Policy.
- HEGGENHOUGEN, H. K., VAUGH, P., MUHONDWA, E. & RUTABANZIBWA-NGAIZA, J. 1987. *Community Health Workers: The Tanzanian Experience*, Oxford, Oxford University Press.

- HERNÁNDEZ, A. R., HURTIG, A.-K., DAHLBLOM, K. & SAN SEBASTIÁN, M. 2014. More than a checklist: a realist evaluation of supervision of mid-level health workers in rural Guatemala. *BMC health services research*, 14, 112.
- HILL, Z., DUMBAUGH, M., BENTON, L., KÅLLANDER, K., STRACHAN, D., TEN ASBROEK, A., TIBENDERANA, J., KIRKWOOD, B. & MEEK, S. 2014. Supervising community health workers in low-income countries—a review of impact and implementation issues. *Global health action*, 7, 24085.
- HINDS, R. & HARLEY, J. 2001. Exploring the experiences of beginning registered nurses entering the acute care setting. *Contemporary Nurse*, 10, 110-116.
- HOLLAND, J. L., JOHNSTON, J. A. & ASAMA, N. F. 1993. The Vocational Identity Scale: A Diagnostic and Treatment Tool. *Journal of Career Assessment*, 1, 1-12.
- HOLLANDER, J. A. 2004. The Social Contexts of Focus Groups. *Journal of Contemporary Ethnography*, 33, 602-637.
- HSIAO, W. C. 1984. Transformation of health care in China. *New England Journal of Medicine*, 310, 932-936.
- HUGHES, D. & DUMONT, K. 1993. Using focus groups to facilitate culturally anchored research. *American Journal of Community Psychology*, 21, 775-806.
- IBARRA, H. 1999. Provisional Selves: Experimenting with Image and Identity in Professional Adaptation. *Administrative Science Quarterly*, 44, 764-791.
- IBRAZ, T. S. 1993. The cultural context of women's productive invisibility: A case study of a Pakistani village. *The Pakistan Development Review*, 101-125.
- IQBAL, N. 2014. SC orders regularisation of 366 LHWs in capital. *The News* October 24, 2014.
- IQTIDARUDDIN, F. S. 2012. Police baton-charge protesting lady health workers at Karachi Press Club. *Business Recorder*, February 15, 2012.
- ISRAN, S. & ISRAN, M. A. 2013. Low Female Labour Participation in Pakistan: Causes and Consequences. *Pakistan Journal of Social Sciences (PJSS)*, 33.
- IYER, V. 2013. Female health workers in Gujarat: Examining human resource actions and workforce objectives—an exploratory mixed methods study.
- JASKIEWICZ, W. & TULENKO, K. 2012. Increasing community health worker productivity and effectiveness: a review of the influence of the work environment. *Human resources for health*, 10, 38.
- JAVANPARAST, S., BAUM, F., LABONTE, R. & SANDERS, D. 2011. Community health workers' perspectives on their contribution to rural health and well-being in Iran. *American Journal of Public Health*, 101, 2287-2292.
- JOHNSON, A. D., THOMSON, D. R., ATWOOD, S., ALLEY, I., BECKERMAN, J. L., KONE, I., DIAKITE, D., DIALLO, H., TRAORE, B. & TRAORE, K. 2013. Assessing early access to care and child survival during a health system strengthening intervention in Mali: a repeated cross sectional survey. *PloS one*, 8, e81304.
- JOHNSON, M., COWIN, L. S., WILSON, I. & YOUNG, H. 2012. Professional identity and nursing: contemporary theoretical developments and future research challenges. *International nursing review*, 59, 562-569.
- JUNAIDI, I. 2013. 100,000 lady health workers get their service regularized. *Dawn*, January 21 2013.
- KABEER, N. 1994. *Reversed realities: Gender hierarchies in development thought*, Verso.
- KABEER, N. 1999. Resources, agency, achievements: Reflections on the measurement of women's empowerment. *Development and Change*, 30, 435-464.
- KABEER, N. 2005. Gender equality and women's empowerment: A critical analysis of the third millennium development goal 1. *Gender & Development*, 13, 13-24.
- KAHSSAY, H. M., TAYLOR, M. E., BERMAN, P. & ORGANIZATION, W. H. 1998. Community health workers: the way forward.
- KALER, A. & WATKINS, S. C. 2001. Disobedient Distributors: Street-level Bureaucrats and Would-be Patrons in Community-based Family Planning Programs in Rural Kenya. *Studies in family planning*, 32, 254-269.
- KALMUS, V. 2006. Socialisation in the changing learning environment: Some considerations for research.
- KALYANGO, J. N., RUTEBEMBERWA, E., ALFVEN, T., SSALI, S., PETERSON, S. & KARAMAGI, C. 2012. Performance of community health workers under integrated

- community case management of childhood illnesses in eastern Uganda. *Malaria Journal*, 11, 282.
- KANE, S. S., GERRETSEN, B., SCHERPBIER, R., DAL POZ, M. & DIELEMAN, M. 2010. A realist synthesis of randomised control trials involving use of community health workers for delivering child health interventions in low and middle income countries. *BMC health services research*, 10, 286.
- KAUFFMAN, K. S. & MYERS, D. H. 1997. The changing role of village health volunteers in northeast Thailand : an ethnographic field study. *International Journal of Nursing Studies*, 34, 249–255.
- KERBER, K. J., DE GRAFT, J., BHUTTA, Z., OKONG, P., STARRS, A. & LAWN, J. 2007. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. *The Lancet*, 370, 1358-1369.
- KHAN, A. 1999. Mobility of Women and Access to Health and Family Planning Services in Pakistan. *Reproductive Health Matters*, 7, 39-48.
- KHAN, A. 2008. Women's empowerment and the lady health worker programme in Pakistan. Karachi: Collective for Social Science Research,.
- KHAN, A. 2011a. Lady Health Workers and Social Change in Pakistan *Economic and Political Weekly*, 46, 28-31.
- KHAN, A. 2011b. Lady health workers and social change in Pakistan. *Economic and Political Weekly*, 28-31.
- KHAN, R. E. A. & KHAN, T. 2009. Labor force participation of married women in Punjab (Pakistan). *Journal of Economic and Social research*, 11, 77.
- KHAN, S. H., CHOWDHURY, A., KARIM, F. & BARUA, M. K. 1998a. Training and retaining Shasthyo Shebika: reasons for turnover of community health workers in Bangladesh. *The Health care supervisor*, 17, 37-47.
- KHAN, S. H., CHOWDHURY, A. M., KARIM, F. & BARUA, M. K. 1998b. Training and retaining Shasthyo Shebika: reasons for turnover of community health workers in Bangladesh. *Health Care Superv*, 17, 37-47.
- KIGER, A. K. 1993. Accord and discord in students' images of nursing. *Journal of Nursing Education*, 32, 309-317.
- KIRONDE, S. & KLAASEN, S. 2002. What motivates lay volunteers in high burden but resource-limited tuberculosis control programmes? Perceptions from the Northern Cape province, South Africa. *The International Journal of Tuberculosis and Lung Disease*, 6, 104-110.
- KISHOR, S. Year. Women's contraceptive use in Egypt: What do direct measures of empowerment tell us? *In: annual meeting of the Population Association of America*, Los Angeles, 2000. 23-25.
- KITZINGER, J. 1994. The methodology of focus groups: the importance of interactions between research participants. *Sociology of Health and Illness*, 16, 103-21.
- KITZINGER, J. 1995. Qualitative Research: Introducing focus groups *British Medical Journal*, 311, 299-302.
- KNETTEL, B. A., SLIFKO, S. E., INMAN, A. G. & SILOVA, I. 2017. Training community health workers: an evaluation of effectiveness, sustainable continuity, and cultural humility in an educational program in rural Haiti. *International Journal of Health Promotion and Education*, 1-12.
- KOK, M. C., BROERSE, J. E., THEOBALD, S., ORMEL, H., DIELEMAN, M. & TAEGTMEYER, M. 2017a. Performance of community health workers: situating their intermediary position within complex adaptive health systems. *Human resources for health*, 15, 59.
- KOK, M. C., DIELEMAN, M., TAEGTMEYER, M., BROERSE, J. E., KANE, S. S., ORMEL, H., TIJM, M. M. & DE KONING, K. A. 2014. Which intervention design factors influence performance of community health workers in low-and middle-income countries? A systematic review. *Health policy and planning*, 30, 1207-1227.
- KOK, M. C., KANE, S. S., TULLOCH, O., ORMEL, H., THEOBALD, S., DIELEMAN, M., TAEGTMEYER, M., BROERSE, J. E. & DE KONING, K. A. 2015. How does context influence performance of community health workers in low-and middle-income countries? Evidence from the literature. *Health research policy and systems*, 13, 13.
- KOK, M. C., ORMEL, H., BROERSE, J. E., KANE, S., NAMAKHOMA, I., OTISO, L., SIDAT, M., KEA, A. Z., TAEGTMEYER, M. & THEOBALD, S. 2017b. Optimising the benefits

- of community health workers' unique position between communities and the health sector: A comparative analysis of factors shaping relationships in four countries. *Global public health*, 12, 1404-1432.
- KOUYATÉ, B., SOMÉ, F., JAHN, A., COULIBALY, B., ERIKSEN, J., SAUERBORN, R., GUSTAFSSON, L., TOMSON, G., BECHER, H. & MUELLER, O. 2008. Process and effects of a community intervention on malaria in rural Burkina Faso: randomized controlled trial. *Malaria Journal*, 7, 50.
- KROGER, J. & MARCIA, J. E. 2011. The identity statuses: Origins, meanings, and interpretations. *Handbook of identity theory and research*. Springer.
- KRUEGER, R. A. 1993. *Quality control in focus group research*, Newbury Park, CA, Sage.
- LAMBERT, S. D. & LOISELLE, C. G. 2008. Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, 62, 228-237.
- LAVE, J. & WENGER, E. 1991a. *Situated learning : legitimate peripheral participation*, Cambridge : Cambridge University Press.
- LAVE, J. & WENGER, E. 1991b. *Situated learning : legitimate peripheral participation / Jean Lave, Etienne Wenger*, Cambridge : Cambridge University Press, c1991.
- LEHMANN, U., FRIEDMAN, I. & SANDERS, D. 2004. Review of the utilisation and effectiveness of community-based health workers in Africa. *Global Health Trust, Joint Learning Initiative on Human Resources for Health and Development (JLI), JLI Working Paper*, 4-1.
- LEHMANN, U. & SANDERS, D. 2007. Community health workers: what do we know about them. *The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers*. Geneva: World Health Organization, 1-42.
- LENER, G. 1986. *The creation of patriarchy*, Oxford University Press, USA.
- LEWIN, S., MUNABI-BABIGUMIRA, S., GLENTON, C., DANIELS, K., BOSCH-CAPBLANCH, X., VAN WYK, B. E., ODGAARD-JENSEN, J., JOHANSEN, M., AJA, G. N. & ZWARENSTEIN, M. 2010. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *The Cochrane Library*.
- LINDELOW, M. & SERNEELS, P. 2006. The performance of health workers in Ethiopia: results from qualitative research. *Social science & medicine*, 62, 2225-2235.
- LIU, A., SULLIVAN, S., KHAN, M., SACHS, S. & SINGH, P. 2011. Community health workers in global health: scale and scalability. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, 78, 419-435.
- LOVE, M. B., GARDNER, K. & LEGION, V. 1997. Community health workers: who they are and what they do. *Health Educ Behav*, 24, 510-22.
- LUKE, N. & MUNSHI, K. 2011. Women as agents of change: Female income and mobility in India. *Journal of Development Economics*, 94, 1-17.
- MACDONALD, M., SPRENGER, E. & DUBEL, I. 1997. *Gender and organizational change: bridging the gap between policy and practice*, Amsterdam, Royal Tropical Institute.
- MACINKO, J., DE SOUZA, M. D. F. M., GUANAIS, F. C. & DA SILVA SIMOES, C. C. 2007. Going to scale with community-based primary care: an analysis of the family health program and infant mortality in Brazil, 1999–2004. *Social science & medicine*, 65, 2070-2080.
- MACINTOSH, J. 2003. Reworking Professional Nursing Identity. *Western Journal of Nursing Research*, 25, 725-745.
- MACKAY, D. M. 1982. Primary Health care may be needed but is it wanted ? . *World Health Forum*, 3, 88-89.
- MACKINTOSH, C. 2006. Caring: the socialisation of pre-registration student nurses: a longitudinal qualitative descriptive study. *International Journal of Nursing Studies*, 43, 953-962.
- MAES, K. 2015. "Volunteers Are Not paid because they Are priceless": community health worker capacities and values in an AIDS treatment intervention in urban Ethiopia. *Medical Anthropology Quarterly*, 29, 97-115.
- MAES, K., CLOSSER, S. & KALOFONOS, I. 2014. Listening to community health workers: how ethnographic research can inform positive relationships among community health workers, health institutions, and communities. *American Journal of Public Health*, 104, e5-e9.

- MAES, K. & KALOFONOS, I. 2013. Becoming and remaining community health workers: perspectives from Ethiopia and Mozambique. *Social science & medicine*, 87, 52-59.
- MALCARNEY, M. B., PITTMAN, P., QUIGLEY, L., HORTON, K. & SEILER, N. 2017. The changing roles of community health workers. *Health services research*, 52, 360-382.
- MANDELBAUM, D. G. 1993. *Women's seclusion and men's honor: Sex roles in North India, Bangladesh, and Pakistan*, University of Arizona Press.
- MANDERSON, L., BENNETT, E. & ANDAJANI-SUTJAHJO, S. 2006. The Social Dynamics of the Interview: Age, Class, and Gender. *Qualitative Health Research*, 16, 1317-1334.
- MANTZOUKAS, S. 2004. Issues of representation within qualitative inquiry. *Qualitative Health Research*, 14, 994-1007.
- MARCH, C., SMYTH, I. A. & MUKHOPADHYAY, M. 1999. *A guide to gender-analysis frameworks*, Oxfam.
- MARMOT, M., FRIEL, S., BELL, R., HOUWELING, T. A. J. & TAYLOR, S. 2008. Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, 372, 1661-1669.
- MARQUEZ, L. & KEAN, L. 2002. Making supervision supportive and sustainable: new approaches to old problems.
- MARU, R. M. 1983. The community health volunteer scheme in India: an evaluation. *Social Science and Medicine*, 17 1477-1483.
- MASON, K. O. & SMITH, H. L. 2000. Husbands' versus wives' fertility goals and use of contraception: The influence of gender context in five Asian countries. *Demography*, 37, 299-311.
- MAUPIN, J. N. 2011. Divergent Models of Community Health Workers in Highland Guatemala. *Human Organization*, 70, 44-53.
- MCCREARY, L. L., KAPONDA, C. P., DAVIS, K., KALENGAMALIRO, M. & NORR, K. F. 2013. Empowering peer group leaders for HIV prevention in Malawi. *Journal of Nursing Scholarship*, 45, 288-297.
- MCKEOWN, T. 2014. *The role of medicine: dream, mirage, or nemesis?*, Princeton University Press.
- MERTON, R. K., READER, G. & KENDALL, P. L. 1957. The student physician: Introductory studies in the sociology of medical education.
- MICHAEL, M. 1996. *Constructing identities: The social, the nonhuman and change*, Sage.
- MILLER, S. E. 2010. A conceptual framework for the professional socialization of social workers. *Journal of Human Behavior in the Social Environment*, 20, 924-938.
- MINISTRY OF HEALTH 2003. PC-1: The Lady Health Workers Programme 2003 - 2008. Islamabad: Government of Pakistan.
- MLOTSHWA, L., HARRIS, B., SCHNEIDER, H. & MOSHABELA, M. 2015. Exploring the perceptions and experiences of community health workers using role identity theory. *Global health action*, 8, 28045.
- MOORE, W. E. 1969. *Handbook of socialization theory and research*, Chicago : Rand McNally, [1969].
- MOORE, W. E. 1970. *The professions: Roles and rules*, Russell Sage Foundation.
- MORÇÖL, G. 2001. Positivist beliefs among policy professionals: An empirical investigation. *Policy Sciences*, 34, 381-401.
- MORGAN, D. L. 1996. Focus Groups. *Annual Review of Sociology*, 22, 129-152.
- MORSE, J. M. 2000. Researching illness and injury: Methodological considerations.
- MOSER, C. O. 2012. *Gender planning and development: Theory, practice and training*, Routledge.
- MPEMBENI, R. N., BHATNAGAR, A., LEFEVRE, A., CHITAMA, D., URASSA, D. P., KILEWO, C., MDEE, R. M., SEMU, H., WINCH, P. J. & KILLEWO, J. 2015. Motivation and satisfaction among community health workers in Morogoro Region, Tanzania: nuanced needs and varied ambitions. *Human resources for health*, 13, 44.
- MULLANY, B. C., HINDIN, M. J. & BECKER, S. 2005. Can women's autonomy impede male involvement in pregnancy health in Katmandu, Nepal? *Social science & medicine*, 61, 1993-2006.
- MUMTAZ, Z., LEVAY, A. V. & BHATTI, A. 2015. Successful community midwives in Pakistan: An asset-based approach. *PloS one*, 10, e0135302.

- MUMTAZ, Z. & SALWAY, S. 2005. 'I never go anywhere': extricating the links between women's mobility and uptake of reproductive health services in Pakistan. *Social Science and Medicine*, 60, 1751-1765.
- MUMTAZ, Z. & SALWAY, S. 2009. Understanding gendered influences on women's reproductive health in Pakistan: Moving beyond the autonomy paradigm. *Social Science and Medicine*, 68, 1349-1356.
- MUMTAZ, Z., SALWAY, S., WASEEM, M. & UMER, N. 2003a. Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. *Health policy and planning*, 18, 261-269.
- MUMTAZ, Z., SALWAY, S., WASEEM, M. & UMER, N. 2003b. Gender based barriers to primary health care provision in Pakistan: the experience of female providers. *Health Policy and Planning*, 18, 261-269.
- NAIMOLI, J. F., FRYMUS, D. E., WULIJI, T., FRANCO, L. M. & NEWSOME, M. H. 2014. A community health worker "logic model": towards a theory of enhanced performance in low-and middle-income countries. *Human resources for health*, 12, 56.
- NDIMA, S. D., SIDAT, M., ORMEL, H., KOK, M. C. & TAEGTMEYER, M. 2015. Supervision of community health workers in Mozambique: a qualitative study of factors influencing motivation and programme implementation. *Human resources for health*, 13, 63.
- NEWELL, K. W. 1988. Selective primary health care: the counter revolution. *Social Science and Medicine*, 26, 903-906.
- NEWELL, K. W., W.H.O 1975. Health by the people.
- NHSRC, N. 2010. ASHA: Which Way Forward. Evaluation of the ASHA Programme.
- NIAZI, A. 2012. Expressions of modernity in rural Pakistan: searching for emic perspectives.
- NICHOLSON, N. 1984. "A theory of work role transitions.". *Administrative Science Quarterly*, 29, 172-191.
- NICHTER, M. A. 1986. The primary health center as a social system: PHC, social status, and the issue of team-work in South Asia. *Social Science and Medicine*, 23, 347-355.
- NSABAGASANI, X., KÄLLANDER, K., PETERSON, S., PARIYO, G. & TOMSON, G. 2007. Home-based management of fever in rural Uganda: community perceptions and provider opinions. *Malaria Journal*, 6, 11.
- OAKLEY, A. 2016. *Sex, gender and society*, Routledge.
- OBILADE, T. T. Village health workers: considering their potential role in the current ebola Virus disease (eVd) outbreak.
- OFOSU-AMAAH, V. & WHO 1983. National experience in the use of community health workers: a review of current issues and problems.
- OKELLO, D. R. & GILSON, L. 2015. Exploring the influence of trust relationships on motivation in the health sector: a systematic review. *Human resources for health*, 13, 16.
- OLANIRAN, A., SMITH, H., UNKELS, R., BAR-ZEEV, S. & VAN DEN BROEK, N. 2017. Who is a community health worker?—a systematic review of definitions. *Global health action*, 10, 1272223.
- OLIVEIRA-CRUZ, V., KUROWSKI, C. & MILLS, A. 2003. Delivery of priority health services: searching for synergies within the vertical versus horizontal debate. *Journal of International Development: The Journal of the Development Studies Association*, 15, 67-86.
- OLIVER, M., GENIETS, A., WINTERS, N., REGA, I. & MBAE, S. M. 2015. What do community health workers have to say about their work, and how can this inform improved programme design? A case study with CHWs within Kenya. *Global health action*, 8, 27168.
- ONWUEGBUZIE, A. & LEECH, N. 2007. A Call for Qualitative Power Analyses. *Quality and Quantity*, 41, 105-121.
- ONWUEGBUZIE, A. J. & LEECH, N. L. 2005. On becoming a pragmatic researcher: The importance of combining quantitative and qualitative research methodologies. *International journal of social research methodology*, 8, 375-387.
- OOMS, G., VAN DAMME, W., BAKER, B. K., ZEITZ, P. & SCHRECKER, T. 2008. The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems? *Globalization and health*, 4, 6.



- ORENSTEIN, W. A. & SEIB, K. 2016. Beyond vertical and horizontal programs: a diagonal approach to building national immunization programs through measles elimination. Taylor & Francis.
- OXFORD POLICY MANAGEMENT 2002. Evaluation of the National Program for Family Planning and Primary Health Care: Lady Health Worker Programme.
- OXFORD POLICY MANAGEMENT 2009. Evaluation of the National Program for Family Planning and Primary Health Care: Lady Health Worker Programme.
- PADFIELD, M. & PROCTOR, I. 1996. The Effect of Interviewer's Gender of the Interviewing Process: A Comparative Enquiry. *Sociology*, 30, 355-366.
- PAINA, L. & PETERS, D. H. 2011. Understanding pathways for scaling up health services through the lens of complex adaptive systems. *Health policy and planning*, 27, 365-373.
- PAINTAIN, L. S., WILLEY, B., KEDENGE, S., SHARKEY, A., KIM, J., BUJ, V., WEBSTER, J., SCHELLENBERG, D. & NGONGO, N. 2014. Community health workers and stand-alone or integrated case management of malaria: a systematic literature review. *The American journal of tropical medicine and hygiene*, 91, 461-470.
- PAKISTAN, G. O. 1993. 8th five year plan 1993-98. In: DEVELOPMENT, M. O. P. A. (ed.). Islamabad
- PAKISTAN., G. O. 2005. Economic Survey Of Pakistan 2004-05. In: FINANCE, M. O. (ed.).
- PALAZUELOS, D., ELLIS, K., DAEUN IM, D., PECKARSKY, M., SCHWARZ, D., BERTRAND FARMER, D., DHILLON, R., JOHNSON, A., ORIHUELA, C. & HACKETT, J. 2013. 5-SPICE: the application of an original framework for community health worker program design, quality improvement and research agenda setting. *Global health action*, 6, 19658.
- PALLAS, S. W., MINHAS, D., PÉREZ-ESCAMILLA, R., TAYLOR, L., CURRY, L. & BRADLEY, E. H. 2013. Community health workers in low-and middle-income countries: what do we know about scaling up and sustainability? *American Journal of Public Health*, 103, e74-e82.
- PAPANEK, H. 1982. Purdah in Pakistan: seclusion and modern occupations for women. *Separate worlds*, 190-216.
- PARKER, A. R. 1993. Another point of view: a manual on gender analysis training for grassroots workers. *Another point of view: a manual on gender analysis training for grassroots workers*.
- PARLATO, M. B. & FAVIN, M. N. 1982. Primary health care: progress and problems. An analysis of 52 AID-assisted projects.
- PATEL, A. R. & NOWALK, M. P. 2010. Expanding immunization coverage in rural India: A review of evidence for the role of community health workers. *Vaccine*, 28, 604-613.
- PATTON, M. Q. 1999. Enhancing the Quality and Credibility of Qualitative Analysis. *Health Services Research*, 34, 1189-1208.
- PÉREZ, L. M. & MARTINEZ, J. 2008. Community health workers: social justice and policy advocates for community health and well-being. *American Journal of Public Health*, 98, 11-14.
- PERRY, H. & ZULLIGER, R. 2012. How effective are community health workers. *An overview of current evidence with recommendations for strengthening community health worker programs to accelerate progress in achieving the health-related Millennium Development Goals*. Baltimore: Johns Hopkins Bloomberg School of Public Health.
- PERRY, H., ZULLIGER, R., SCOTT, K., JAVADI, D. & GERGEN, J. 2013. Case studies of Large-Scale community health worker programs: examples from Bangladesh, Brazil, Ethiopia, India, Iran, Nepal, and Pakistan. *Afghanistan: Community-Based Health Care to the Ministry of Public Health*.
- PERRY, H. B., DHILLON, R. S., LIU, A., CHITNIS, K., PANJABI, R., PALAZUELOS, D., KOFFI, A. K., KANDEH, J. N., CAMARA, M. & CAMARA, R. 2016. Community health worker programmes after the 2013–2016 Ebola outbreak. *Bulletin of the World Health Organization*, 94, 551.
- PERRY, H. B., RASSEKH, B. M., GUPTA, S., WILHELM, J. & FREEMAN, P. A. 2017. Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 1. rationale, methods and database description. *Journal of global health*, 7.

- PERRY, H. B., ZULLIGER, R. & ROGERS, M. M. 2014. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annual review of public health*, 35, 399-421.
- PILHAMMAR ANDERSSON, E. 1993. The perspective of student nurses and their perceptions of professional nursing during the nurse training programme. *Journal of Advanced Nursing*, 18, 808.
- PLANNING COMMISSION 2010. Pakistan Millennium Development Goals, Report 2010. Islamabad: Government of Pakistan.
- POLKINGHORNE, D. E. 2005. Language and meaning: Data collection in qualitative research. *Journal of counseling psychology*, 52, 137.
- PORTER, G. 2011. 'I think a woman who travels a lot is befriending other men and that's why she travels': mobility constraints and their implications for rural women and girls in sub-Saharan Africa. *Gender, place and culture*, 18, 65-81.
- PRASAD, B. & MURALEEDHARAN, V. 2008. CHWs: a review of concepts, practice and policy concerns. London: CREHS.
- PRICE, S. L. 2009. Becoming a nurse: a meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing*, 65, 11-19.
- PRING, R. 2000. The 'false dualism' of educational research. *Journal of Philosophy of Education*, 34, 247-260.
- RABBANI, F., PERVEEN, S., AFTAB, W., ZAHIDIE, A., SANGRASI, K. & QAZI, S. A. 2016. Health workers' perspectives, knowledge and skills regarding community case management of childhood diarrhoea and pneumonia: a qualitative inquiry for an implementation research project "Nigraan" in District Badin, Sindh, Pakistan. *BMC health services research*, 16, 462.
- RAHMAN, S. M., ALI, N. A., JENNINGS, L., SERAJI, M. H. R., MANNAN, I., SHAH, R., AL-MAHMUD, A. B., BARI, S., HOSSAIN, D. & DAS, M. K. 2010. Factors affecting recruitment and retention of community health workers in a newborn care intervention in Bangladesh. *Human resources for health*, 8, 12.
- RAMEY, H. L. & GRUBB, S. 2009. Modernism, postmodernism and (evidence-based) practice. *Contemporary family therapy*, 31, 75-86.
- RAMIREZ-VALLES, J. 1998a. Promoting health, promoting women: the construction of female and professional identities in the discourse of community health workers. *Social science & medicine*, 47, 1749-1762.
- RAMIREZ-VALLES, J. 1998b. Promoting health, promoting women: the construction of female and professional identities in the discourse of community health workers. *Social Science & Medicine*, 47, 1749-1762.
- RAMIREZ-VALLES, J. 1999. Changing Women: The Narrative Construction of Personal Change Through Community Health Work Among Women in Mexico. *Health Education and Behavior*, 26, 25-42.
- RAMIREZ-VALLES, J. 2001. "I was not invited to a [CHW]... I asked to be one": motives for community mobilization among women community health workers in Mexico. *Health Education and Behavior*, 28, 150-165.
- RAMIREZ-VALLES, J. 2003. Translocal and gender dimensions of frame alignment: community mobilization and recruitment processes among women community health workers in Mexico. *Critical Public Health*, 13, 207-230.
- RASKIN, J. D. 2008. The evolution of constructivism. *Journal of constructivist psychology*, 21, 1-24.
- RAWAT, P. S. 2014. Patriarchal beliefs, women's empowerment, and general well-being. *Vikalpa*, 39, 43-56.
- REDICK, C. & DINI, H. 2014. The current state of CHW training programs in Sub-Saharan Africa and South Asia: What we know what we don't know and what we need to do.
- RICE-MARQUEZ, N., BAKER, T. D. & FISCHER, C. 1988. The community health worker: forty years of experience of an integrated primary rural health care system in Brazil. *The Journal of Rural Health*, 4, 87-100.
- RICHARDSON, B. 1999. Professional development: 2. Professional knowledge and situated learning in the workplace. *Physiotherapy*, 85, 467-474.
- RICOEUR, P. 1992. *Oneself as another*, University of Chicago Press.
- RIFKIN, S. (ed.) 2008. *Community health workers*: Academic Press.

- RIFKIN, S. B. 2018a. Alma Ata after 40 years: Primary Health Care and Health for All—from consensus to complexity. *BMJ global health*, 3, e001188.
- RIFKIN, S. B. 2018b. Oxford Research Encyclopedia of Global Public Health.
- RIFKIN, S. B. & WALT, G. 1986. Why health improves: defining the issues concerning 'comprehensive primary health care' and 'selective primary health care'. *Social science & medicine*, 23, 559-566.
- RITCHIE, J. & LEWIS, J. (eds.) 2003. *Qualitative Research Practice. A guide for Social Science Students and Researchers*: Sage Publications.
- RITCHIE, J., LEWIS, J., NICHOLLS, C. M. & ORMSTON, R. 2013. *Qualitative research practice: A guide for social science students and researchers*, Sage.
- RIZVI, N., KHAN, K. S. & SHAIKH, B. T. 2014. Gender: shaping personality, lives and health of women in Pakistan. *BMC women's health*, 14, 53.
- ROBERTON, T., APPLGATE, J., LEFEVRE, A. E., MOSHA, I., COOPER, C. M., SILVERMAN, M., FELDHAUS, I., CHEBET, J. J., MPEMBENI, R. & SEMU, H. 2015. Initial experiences and innovations in supervising community health workers for maternal, newborn, and child health in Morogoro region, Tanzania. *Human resources for health*, 13, 19.
- ROBINSON, S. A. & LARSEN, D. E. 1990. The relative influence of the community and the health system on work performance: a case study of community health workers in Colombia. *Social science & medicine*, 30, 1041-1048.
- RÖDLACH, A. 2009. Home-based care for people living with AIDS in Zimbabwe: voluntary caregivers' motivations and concerns. *African Journal of AIDS research*, 8, 423-431.
- RODNEY, M., CLASEN, C., GOLDMAN, G., MARKERT, R. & DEANE, D. 1998. Three evaluation methods of a community health advocate program. *Journal of Community Health*, 23, 371-381.
- ROHDE, J., COUSENS, S., CHOPRA, M., TANGCHAROENSATHIEN, V., BLACK, R., BHUTTA, Z. A. & LAWN, J. E. 2008. 30 years after Alma-Ata: has primary health care worked in countries? *The Lancet*, 372, 950-961.
- RONAGHY, H. A., NAJARZADEH, E., SCHWARTZ, T. A., RUSSEL, S. S., SOLTER, S. & ZEIGHAMI, B. 1976. The front line health worker: selection, training, and performance. *American Journal of Public Health*, 66, 273-277.
- ROWE, A. K., DE SAVIGNY, D., LANATA, C. F. & VICTORA, C. G. 2005. How can we achieve and maintain high-quality performance of health workers in low-resource settings? *The Lancet*, 366, 1026-1035.
- RUEBUSH II, T. K., WELLER, S. C. & KLEIN, R. E. 1994. Qualities of an ideal volunteer community malaria worker: a comparison of the opinions of community residents and national malaria service staff. *Social science & medicine*, 39, 123-131.
- SANDELOWSKI, M. 2002. Reembodying qualitative inquiry. *Qualitative Health Research*, 12, 104-115.
- SANDERS, D. M., TODD, C. & CHOPRA, M. 2005. Confronting Africa's health crisis: more of the same will not be enough. *British Medical Journal*, 331, 755-758.
- SARFRAZ, M. & HAMID, S. 2014. Challenges in delivery of skilled maternal care—experiences of community midwives in Pakistan. *BMC pregnancy and childbirth*, 14, 59.
- SARUP, M. 1996. Identity, culture and the postmodern world.
- SATHAR, Z. A. & KAZI, S. 1997. Women's autonomy, livelihood and fertility: a study of rural Punjab. *Women's autonomy, livelihood and fertility: a study of rural Punjab*.
- SATHAR, Z. A. & KAZI, S. 2000. Women's autonomy in the context of rural Pakistan. *The Pakistan Development Review*, 89-110.
- SAYER, A. 1997. Essentialism, social constructionism, and beyond. *The Sociological Review*, 45, 453-487.
- SCHEIN, E. H. 1978. *Career Dynamics: Matching Individual and Organizational Needs*, Reading, MA, Addison-Wesley.
- SCHMIDT, V. H. 2001. Oversocialised epistemology: A critical appraisal of constructivism. *Sociology*, 35, 135-157.
- SCHNEIDER, H., HLOPHE, H. & VAN RENSBURG, D. 2008. Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health Policy and Planning*, 23, 179-187.

- SCHNEIDER, H. & LEHMANN, U. 2010. Lay health workers and HIV programmes: implications for health systems. *AIDS Care*, 22 Suppl 1, 60-67.
- SCHULZ, A. J., ISRAEL, B. A., BECKER, A. B. & HOLLIS, R. M. 1997. "It's a 24-Hour Thing... a Living-for-Each-other Concept": Identity, Networks, and Community in an Urban Village Health Worker Project. *Health Education & Behavior*, 24, 465-480.
- SCHWANDT, T. A. 2001. Dictionary of qualitative inquiry.
- SCHWARZER, A. 1984. *After The second sex: conversations with Simone de Beauvoir*, Pantheon Books New York.
- SCOTT, D. 2005. Critical realism and empirical research methods in education. *Journal of Philosophy of Education*, 39, 633-646.
- SCOTT, J. L., CROMPTON, R. & LYONETTE, C. 2010. *Gender inequalities in the 21st century: new barriers and continuing constraints*, Edward Elgar Publishing.
- SCOTT, K., BECKHAM, S., GROSS, M., PARIYO, G., RAO, K. D., COMETTO, G. & PERRY, H. B. 2018. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human resources for health*, 16, 39.
- SCOTT, K. & SHANKER, S. 2010. Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India. *AIDS care*, 22, 1606-1612.
- SEN, A. 1987. *Gender and cooperative conflicts*, Wider Helsinki.
- SERRA, M. N. 2008. Learning to be a nurse. Professional identity in nursing students. *Sísifo. Educational Sciences Journal*, 5, 65-76.
- SHAHID, A. 2012. Lady health workers take protest to another level *Dawn*, April 19, 2012.
- SHAIKH, B. T., HARAN, D. & HATCHER, J. 2008. Women's Social Position and Health-Seeking Behaviors: Is the Health Care System Accessible and Responsive in Pakistan? *Health Care for Women International*, 29, 945-959.
- SHEIKH, K., GILSON, L., AGYEPONG, I. A., HANSON, K., SSENGOOBA, F. & BENNETT, S. 2011. Building the field of health policy and systems research: framing the questions. *PLoS medicine*, 8, e1001073.
- SHEIKH, K., RANSON, M. K. & GILSON, L. 2014. Explorations on people centredness in health systems. *Health policy and planning*, 29, ii1.
- SHEPARD, C. R. W. 2016. *Who Are They? A Case Study of Community Health Worker (CHW) Programs in Primary Health Care*. University of South Carolina.
- SHI, L. 1993. Health care in China: a rural-urban comparison after the socioeconomic reforms. *Bulletin of World Health Organization*, 71, 723-736.
- SHUVAL, J. T. 1980. *Entering medicine: The dynamics of transition: A seven year study of medical education in Israel*, Pergamon.
- SIDEL, V. W. 1972a. The barefoot doctors of the People's Republic of China. *New England Journal of Medicine*, 286, 1292-1300.
- SIDEL, V. W. 1972b. The barefoot doctors of the People's Republic of China. *New England Journal of Medicine*, 286, 1292-1300.
- SIDEL, V. W. & SIDEL, R. 1977. Primary Health Care in relation to socio political structure. *Social Science and Medicine*, 11, 415-419.
- SILVERMAN, D. 1993. *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, London, Sage.
- SILVERMAN, D. 2015. *Interpreting qualitative data*, Sage.
- SIMPSON, I. H. & BACK, K. W. 1979. *From student to nurse: A longitudinal study of socialization*, CUP Archive.
- SINGH, P. & SULLIVAN, S. 2011. One million community health workers: technical task force report. *New York: Earth Institute at Columbia University*, 304-10.
- SKORIKOV, V. B. & VONDRACEK, F. W. 2011a. Occupational identity. *Handbook of identity theory and research*. Springer.
- SKORIKOV, V. B. & VONDRACEK, F. W. (eds.) 2011b. *Occupational Identity*, New York: Springer.
- SMITH, S., DEVERIDGE, A., BERMAN, J., NEGIN, J., MWAMBENE, N., CHINGAIPE, E., RITCHIE, L. M. P. & MARTINIUK, A. 2014. Task-shifting and prioritization: a situational analysis examining the role and experiences of community health workers in Malawi. *Human resources for health*, 12, 24.

- SQUIRES, A. & O'BRIEN, M. J. 2012. Becoming a promotora: a transformative process for female community health workers. *Hispanic Journal of Behavioral Sciences*, 34, 457-473.
- SRINGERNYUANG, L., HONGVIVATANA, T. & PRADABMUK, P. 1995. Implications of community health workers distributing drugs: A case study of Thailand. Geneva: World Health Organization.
- STANDING, H. & CHOWDHURY, A. M. R. 2008a. Producing effective knowledge agents in a pluralistic environment: What future for community health workers? *Social Science and Medicine*, 66, 2096-2107.
- STANDING, H. & CHOWDHURY, A. M. R. 2008b. Producing effective knowledge agents in a pluralistic environment: what future for community health workers? *Social science & medicine*, 66, 2096-2107.
- STARK, R. 1985. Lay workers in primary health care: victims in the process of social transformation. *Social science & medicine*, 20, 269-275.
- STRACHAN, D. L., KÄLLANDER, K., NAKIRUNDA, M., NDIMA, S., MUIAMBO, A. & HILL, Z. 2015. Using theory and formative research to design interventions to improve community health worker motivation, retention and performance in Mozambique and Uganda. *Human resources for health*, 13, 25.
- STRACHAN, D. L., KÄLLANDER, K., TEN ASBROEK, A. H., KIRKWOOD, B., MEEK, S. R., BENTON, L., CONTEH, L., TIBENDERANA, J. & HILL, Z. 2012. Interventions to improve motivation and retention of community health workers delivering integrated community case management (iCCM): stakeholder perceptions and priorities. *The American journal of tropical medicine and hygiene*, 87, 111-119.
- SULTANA, A. 2010. Patriarchy and Women s Subordination: A Theoretical Analysis. *Arts Faculty Journal*, 1-18.
- SURI, A., GAN, K. & CARPENTER, S. 2007. Voices from the field: perspectives from community health workers on health care delivery in rural KwaZulu-Natal, South Africa. *The Journal of infectious diseases*, 196, S505-S511.
- SUTHERLAND, L., HOWARD, S. & MARKAUSKAITE, L. 2010. Professional identity creation: Examining the development of beginning preservice teachers' understanding of their work as teachers. *Teaching and teacher education*, 26, 455-465.
- SVITONE, E. C., GARFIELD, R., VASCONCELOS, M. I. & CRAVEIRO, V. A. 2000. Primary health care lessons from the Northeast of Brazil: the Agentes de Saúde Program. *Revista Panamericana de Salud Pública*, 7, 293-301.
- SWIDLER, A. & WATKINS, S. C. 2009. "Teach a man to fish": the sustainability doctrine and its social consequences. *World Development*, 37, 1182-1196.
- TAYLOR, B., MATHERS, J. & PARRY, J. 2017. A conceptual framework for understanding the mechanism of action of community health workers services: the centrality of social support. *Journal of Public Health*.
- TAYLOR, C. E. 1976. *Doctors for the villages: Study of rural internships in seven Indian medical colleges*, Asia Publishing House.
- TEKLEHAIMANOT, H. D. & TEKLEHAIMANOT, A. 2013. Human resource development for a community-based health extension program: a case study from Ethiopia. *Human resources for health*, 11, 39.
- THEOBALD, S., HAWKINS, K., KOK, M., RASHID, S., DATIKO, D. & TAEGTMEYER, M. 2016. Close-to-community providers of health care: increasing evidence of how to bridge community and health systems. BioMed Central.
- THEOBALD, S., MACPHERSON, E., MCCOLLUM, R. & TOLHURST, R. Year. Close to community health providers post 2015: Realising their role in responsive health systems and addressing gendered social determinants of health. In: BMC proceedings, 2015. BioMed Central, S8.
- TIERNEY, W. G. 1997. Organizational socialization in higher education. *The Journal of Higher Education*, 68, 1-16.
- TOIT, D. 1995. A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of advanced nursing*, 21, 164-171.
- TUFFORD, L. & NEWMAN, P. 2012. Bracketing in Qualitative Research. *Qualitative Social Work*, 11, 80-96.

- TULENKO, K., MGEDAL, S., AFZAL, M. M., FRYMUS, D., OSHIN, A., PATE, M., QUAIN, E., PINEL, A., WYND, S. & ZODPEY, S. 2013. Community health workers for universal health-care coverage: from fragmentation to synergy. *Bulletin of the World Health Organization*, 91, 847-852.
- TURNER, J. C. 1999. Some current issues in research on social identity and self-categorization theories. *Social identity: Context, commitment, content*, 3, 6-34.
- UGALDE, A. 1985. Ideological dimensions of community participation in Latin America health programs. *Social Science and Medicine* . 21, 41-53.
- UPVALL, M. J., SOCHAEAL, S. & GONSALVES, A. 2002. Behind the mud walls: the role and practice of lady health visitors in Pakistan. *Health Care for Women International*, 23, 432-441.
- VAN GINNEKEN, N., LEWIN, S. & BERRIDGE, V. 2010. The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Social science & medicine*, 71, 1110-1118.
- VAN LERBERGHE, W. 2008. *The world health report 2008: primary health care: now more than ever*, World Health Organization.
- W.H.O 2007. Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines.
- WALBY, S. 1990. *Theorizing patriarchy*, Basil Blackwell.
- WALSH, J. A. & WARREN, K. S. 1980. Selective primary health care: an interim strategy for disease control in developing countries. *Social Science & Medicine. Part C: Medical Economics*, 14, 145-163.
- WALSHAM, G. 1995. Interpretive case studies in IS research: nature and method. *European Journal of Information Systems*, 4, 74-81.
- WALT, G. 1988. CHWs: are national programmes in crisis? *Health policy and planning*, 3, 1-21.
- WALT, G., GILSON, L., HEGGENHOUGEN, K., KNUDSEN, T., OWUOR-OMONDI, L. & PERERA, M. 1990. *Community health workers in national programmes: just another pair of hands?*, Open University Press Philadelphia.
- WALT, G., PERERA, M. & HEGGENHOUGEN, K. 1989. Are large-scale volunteer community health worker programmes feasible? The case of Sri Lanka. *Social science & medicine*, 29, 599-608.
- WARE, S. M. 2008a. Developing a self-concept of nurse in baccalaureate nursing students. *International Journal of Nursing Education Scholarship*, 5, 1-17.
- WARE, S. M. 2008b. Developing a self-concept of nurse in baccalaureate nursing students. *International Journal Of Nursing Education Scholarship*, 5, Article5-Article5.
- WASIF, S. April 17, 2012. Strong ultimatum: Lady health workers threaten to set themselves alight. *Express Tribune*.
- WEICK, K. E. & WESTLEY, F. (eds.) 1996. *"Organizational learning: Affirming an oxymoron."* London: Sage.
- WENGER, E. 1998. *Communities of practice : learning, meaning, and identity / Etienne Wenger*, Cambridge, England : Cambridge University Press, 1998.
- WERNER, D. 1978. The village health worker--lackey or liberator?[proceedings]. *World hospitals*, 14, 32-32.
- WERNER, D. 1980. Health care and human dignity: a subjective look at community-based rural health programs in Latin America. *Contact*, 57, 91-105.
- WERNER, D. 1981a. The Village Health Worker: lackey or liberator. *World Health Forum*, 2, 46-68.
- WERNER, D. 1981b. The village health worker: lackey or liberator? *World Health Forum*, 2, 46-68.
- WHO 1989. Strengthening the performance of community health workers in primary health care: report of a WHO Study Group [meeting held in Geneva from 2 to 9 December 1987].
- WHO 2006. Working together for health. *The World Health Report*. Geneva: World Health Organization.
- WHO 2007a. Community health workers:What do we know about them? Geneva: Evidence and Information for Policy, Department of Human Resources for Health.
- WHO 2007b. Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action.

- WHO 2007c. Role of village health volunteers in avian influenza surveillance in Thailand. WHO Regional Office for South-East Asia.
- WHO 2007d. Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines.
- WHO 2010a. Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems. World Health Organization.
- WHO 2010b. *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*, World Health Organization.
- WHO 2010c. World Health Report, 2010: health systems financing the path to universal coverage. *World Health Report, 2010: health systems financing the path to universal coverage*.
- WHO. Year. From Kampala to Bangkok: Reviewing Progress, Renewing Commitments. *In*: Second Global Forum on Human Resources for Health 2011 Bangkok.
- WHO 2016. Global strategy on human resources for health workforce 2030.
- WHO 2017. World health statistics: Monitoring health for the Sustainable Development Goals.
- WHO. 1989. Strengthening the performance of community health workers in primary health care. *Technical Report Series 780*. Geneva: World Health Organization.
- WHO. & UNICEF. 1978. Primary Health Care, Report on the International Conference on Primary Health Care. *International Conference on Primary Health Care*. International Conference on Primary Health Care ed. Alma Ata, USSR,: World Health Organization.
- WILLIS-SHATTUCK, M., BIDWELL, P., THOMAS, S., WYNESS, L., BLAAUW, D. & DITLOPO, P. 2008. Motivation and retention of health workers in developing countries: a systematic review. *BMC health services research*, 8, 247.
- WINCH, P., BAGAYOKO, A., DIAWARA, A., KANE, M., THIERO, F., GILROY, K., DAOU, Z., BERTHE, Z. & SWEDBERG, E. 2003. Increases in correct administration of chloroquine in the home and referral of sick children to health facilities through a community-based intervention in Bougouni District, Mali. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 97, 481-490.
- WINKVIST, A. & AKHTER, Z. A. 2000. 'God should give daughters to rich families only': attitudes towards childbearing among low-income women in Punjab, Pakistan. *Social Science and Medicine*, 51, 73-81.
- WITMER, A., SEIFER, S. D., FINOCCHIO, L., LESLIE, J. & O'NEIL, E. H. 1995. Community health workers: integral members of the health care work force. *American Journal of Public Health*, 85, 1055-1058.
- WOELK, G. B. 1994. Primary health care in Zimbabwe: Can it survive? : An exploration of the political and historical developments affecting the implementation of PHC. *Social Science and Medicine*, 39, 1027-1035.
- WOLF, D. L. 1990. Daughters, Decisions and Domination: An Empirical and Conceptual Critique of Household Strategies. *Development and Change*, 21, 43-74.
- WOOD, C. S. 1990. Maori community health workers: a mixed reception in New Zealand. *Anthropology and Primary Health Care*, 123.
- ZACHARIAH, R., TECK, R., BUHENDWA, L., FITZERLAND, M., LABANA, S., CHINJI, C., HUMBLET, P. & HARRIES, A. 2007. Community support is associated with better antiretroviral treatment outcomes in a resource-limited rural district in Malawi. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 101, 79-84.
- ZAIN, O. 2010. South Asian Studies A Research Journal of South Asian Studies Vol. 25.
- ZHU, N. S., LING, Z. H., SHEN, J., LANE, J. M. & HU, S. L. 1989. Factors associated with the decline of the Cooperative Medical System and barefoot doctors in rural China. *Bulletin of World Health Organization*, 67, 431-441.
- ZULU, J. M., KINSMAN, J., MICHELO, C. & HURTIG, A.-K. 2014. Integrating national community-based health worker programmes into health systems: a systematic review identifying lessons learned from low-and middle-income countries. *BMC Public Health*, 14, 987.

**Annex -1**  
**Ethical Approval**



Queen Margaret University  
EDINBURGH

Name: Amjad Chaudry  
Status: PhD Student  
Subject Area: IIHD  
School: Health Sciences

Lucy Clapson  
Registry Officer  
Queen Margaret University  
Queen Margaret University Drive  
Musselburgh  
East Lothian EH21 6UU

Tel: 0131 474 0000  
Email: lclapson@qmu.ac.uk

19 December 2012

Dear Amjad

**Ethical Approval – Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**

Thank you for submitting the requested documentation from the relevant District Health Officer granting permission for you to contact potential participants.

Dr Jane McKenzie, Convener of the Panel has confirmed that she is happy to take Convener's Action to grant ethical approval for your study.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. The appropriate form is available here: <http://www.qmu.ac.uk/quality/rs/default.htm#ethics>.

We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely

Lucy Clapson  
Secretary to the Research Ethics Panel





**Information Sheet for Interviews of Lady Health Workers  
Information Sheet for Potential Participants**

My name is **Chaudhry Muhammad Amjad** I am a PhD student from the **Institute for International Health and Development Queen Margaret University in Edinburgh, United Kingdom**. As part of my PhD course, I am undertaking a research project. The title of my project is: **Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**.

This study will investigate how women trained as Lady Health Workers articulate their work experiences and view themselves as health workers within the Pakistani health system. The objectives of this study are to explore the influence of individual life trajectories of women trained as LHWs and collective experiences of LHWs' as they enter and work within the Pakistani health system. The study envisages to understand how community and workplace-based gender dynamics influences the roles, activities, and working practices of LHWs. The findings of the project will be useful because this will enable better understanding of the LHWs as a health provider's cadre.

I am looking for volunteers to participate in the project and all the LHWs are welcome to take part. If you agree to participate in the study, you will be asked to discuss your experiences before and after becoming a LHW. The whole procedure should take no longer than two hours. You will be free to withdraw from the study at any stage and you would not have to give a reason or answer all the questions.

Your interview will be recorded and you may be identifiable from tape recordings of your voice but this recording and your interview contents would not be shared with anyone. The data will be anonymised and your name will be replaced with a participant number, and it will not be possible to identify you in any reporting of the data gathered. The results may however, be published in a journal or presented at a conference or remain unpublished.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Mr.Majid Shahzad. His contact details are given below.

Name: **Majid Shahzad , Instructor**  
Address: **Health Services Academy**  
**Opposite National Institute of Health (NIH)**  
**Chak Shahzad, Islamabad, Pakistan**

Email / Telephone: [majid@hsa.edu.pk](mailto:majid@hsa.edu.pk) 051 9255594

If you have read and understood this information sheet, any questions you have been answered, and you would like to be a participant in the study, please now see the consent form.

Contact details of the researcher

Name of researcher: **Chaudhry Muhammad Amjad**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [achaudhry@gmu.ac.uk](mailto:achaudhry@gmu.ac.uk) / 051 9205881 & ++ 44 131 474 0000

Contact details of the independent adviser (note that the independent adviser cannot be a member of your supervisory team)

Name of adviser: **Professor Barbara McPake, Director**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [bmcpike@gmu.ac.uk](mailto:bmcpike@gmu.ac.uk) / ++ 44 131 474 0000



Queen Margaret University  
EDINBURGH

### لیڈی ہیلتھ ورکرز سے انٹرویو کے لیے معلوماتی صفحہ

میرا نام چوہدری محمد امجد ہے اور میں ادارہ برائے بین الاقوامی صحت اور ترقی، کوئین مارگریٹ یونیورسٹی، برطانیہ میں پی ایچ ڈی کا طالب علم ہوں۔ میں پی ایچ ڈی کورس کے سلسلے میں ایک تحقیقی کام کر رہا ہوں جس کا عنوان ہے ”پاکستانی لیڈی ہیلتھ ورکرز (LHWS) کی پاکستانی معاشرے میں ذاتی اور پیشہ ورانہ حیثیت“

☆ یہ تحقیق اس بات کا جائزہ لے گی کہ تربیت یافتہ LHWS کس طرح پاکستانی نظام صحت میں خود کو دیکھتی ہیں۔  
☆ اس تحقیق کا مقصد اس بات کا جائزہ لینا ہے کہ پاکستانی نظام صحت میں LHWS کو انفرادی اور اجتماعی طور پر کن تجربات کا سامنا کرنا پڑا۔

☆ اس تحقیق کا مقصد ہے کہ LHWS کے کیونٹی اور اپنے کام کے دوران تجربات کا مطالعہ کیا جائے گا۔  
☆ اس تحقیق کے نتائج ہیلتھ ورکرز کے بارے میں اہم آگاہی فراہم کریں گے۔

☆ مجھے اپنی تحقیق کے سلسلے میں ایک رضا کار کی تلاش ہے۔ اور تمام لیڈی ہیلتھ ورکرز اس کام میں شامل ہو سکتی ہیں اگر آپ اس تحقیق میں شمولیت کرنا چاہتے ہیں تو آپ سے لیڈی ہیلتھ ورکر کی حیثیت سے آپ کے تجربات کے بارے میں پوچھا جائے گا اور اگر آپ اس تحقیق میں شامل ہونے کے لئے راضی ہیں تو آپ سے LHWS کے بارے میں بات چیت کی جائے گی۔ جس کا دورانیہ دو گھنٹے سے کم ہوگا۔ آپ بغیر کوئی وجہ بتائے اس تحقیق سے دستبردار ہو سکتے ہیں اور اگر آپ چاہیں تو کسی بھی سوال کا جواب نہ دیں۔

آپ کا انٹرویو ریکارڈ کیا جائے گا اور آپ اپنی آواز سے پہچانے جاسکتے ہیں۔ مگر آپ کا ریکارڈ کیا گیا انٹرویو یا اس کا کوئی بھی حصہ کسی کو بھی نہیں سنایا جائے گا اور اسے صیغہ راز میں رکھا جائے گا۔ آپ کی طرف سے دی گئی تمام معلومات کو خفیہ رکھا جائے گا۔ اور آپ کے علاوہ اس معلومات تک کسی اور کو رسائی نہیں ہوگی۔ اس تحقیق کو کسی بھی تعلیمی جریدے میں شائع کیا جاسکتا ہے۔

☆ اگر آپ کسی آزاد فرد سے اس بارے میں رابطہ کرنا چاہیں جو اس تحقیق کا حصہ نہیں ہے۔ تو آپ مسٹر ماجد شہزاد سے مندرجہ ذیل پتے پر رابطہ کر سکتے ہیں۔

ماجد شہزاد : انسٹرکٹر ہیلتھ سروسز اکیڈمی (وزیراعظم ہیلتھ کمپلیکس) چک شہزاد اسلام آباد

ای میل : majid@hsa.edu.pk

ٹیلی فون : 051-9255594

اگر یہ معلوماتی صفحہ پڑھ اور سمجھ کر آپ کو اپنے سوالات کے جوابات مل گئے ہیں اور آپ میری تحقیق میں شامل ہونا چاہتے ہیں تو آپ مہربانی کر کے کانٹ فارم کو دیکھیں۔

نام اور محقق کا پتہ: چوہدری محمد امجد

ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ ٹوہین شرقی، ای ایچ ۶۲ یو یو، برطانیہ  
ای میل: acaudhry@qmu.ac.uk

ٹیلی فون: 0519205881 ++441314740000

### آزاد مشیر کی تفصیلات

مشیر کا نام: پروفیسر باربرا میک پیک

ڈائریکٹر

ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ ٹوہین شرقی، ای ایچ ۶۲ یو یو، برطانیہ

ای میل: bmcpake@qmu.ac.uk

ٹیلی فون ++441314740000

## Information Sheet for Focus Group Discussion of Lady Health Workers



### Information Sheet for Potential Participants

My name is **Chaudhry Muhammad Amjad** I am a PhD student from the **Institute for International Health and Development Queen Margaret University in Edinburgh, United Kingdom**. As part of my PhD course, I am undertaking a research project. The title of my project is: **Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**.

This study will investigate how women trained as Lady Health Workers articulate their work experiences and view themselves as health workers within the Pakistani health system. The objectives of this study are to explore the influence of individual life trajectories of women trained as LHWs and collective experiences of LHWs' as they enter and work within the Pakistani health system. The study envisages to understand how community and workplace-based gender dynamics influences the roles, activities, and working practices of LHWs. The findings of the project will be useful because this will enable better understanding of the LHWs as a health provider's cadre.

I am looking for volunteers to participate in the project and all the LHWs are welcome to take part. If you agree to participate in the study, you will be asked to discuss your experiences before and after becoming a LHW in a group of LHWs. The whole procedure should take no longer than two hours. You will be free to withdraw from the study at any stage and you would not have to give a reason or answer all the questions.

Your discussion in the group will be recorded and you may be identifiable from tape recordings of your voice but this recording and the contents of the discussion would not be shared with anyone. The data will be anonymised and your name will be replaced with a participant number, and it will not be possible to identify you in any reporting of the data gathered. The results may however, be published in a journal or presented at a conference *or* remain unpublished.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Mr.Majid Shahzad. His contact details are given below.

Name: **Majid Shahzad , Instructor**  
Address: **Health Services Academy**  
**Opposite National Institute of Health (NIH)**  
**Chak Shahzad, Islamabad, Pakistan**

Email / Telephone: [majid@hsa.edu.pk](mailto:majid@hsa.edu.pk) 051 9255594

If you have read and understood this information sheet, any questions you have been answered, and you would like to be a participant in the study, please now see the consent form.

Contact details of the researcher

Name of researcher: **Chaudhry Muhammad Amjad**

Address: **The Institute for International Health and Development,**  
**Queen Margaret University,**  
**Queen Margaret University Drive, Musselburgh,**  
**East Lothian, EH21 6UU,**  
**United Kingdom**

Email / Telephone: [achaudhry@gmu.ac.uk](mailto:achaudhry@gmu.ac.uk) / 051 9205881 & ++ 44 131 474 0000

Contact details of the independent adviser (note that the independent adviser cannot be a member of your supervisory team)

Name of adviser: **Professor Barbara McPake, Director**

Address: **The Institute for International Health and Development,**  
**Queen Margaret University,**  
**Queen Margaret University Drive, Musselburgh,**  
**East Lothian, EH21 6UU,**  
**United Kingdom**

Email / Telephone: [bmcpike@gmu.ac.uk](mailto:bmcpike@gmu.ac.uk) / ++ 44 131 474 0000



Queen Margaret University  
EDINBURGH

### لیڈی ہیلتھ ورکرز سے فوکس گروپ ڈسکشن کے لئے معلوماتی صفحہ

میرا نام چوہدری محمد امجد ہے اور میں ادارہ برائے بین الاقوامی صحت اور ترقی، کونین مارگریٹ یونیورسٹی، برطانیہ میں پی ایچ ڈی کا طالب علم ہوں۔ میں پی ایچ ڈی کورس کے سلسلے میں ایک تحقیقی کام کر رہا ہوں جس کا عنوان ہے ”پاکستانی لیڈی ہیلتھ ورکرز (LHWs) کی پاکستانی معاشرے میں ذاتی اور پیشہ ورانہ حیثیت“

☆ یہ تحقیق اس بات کا جائزہ لے گی کہ تربیت یافتہ LHWs کس طرح پاکستانی نظام صحت میں خود کو دیکھتی ہیں۔  
☆ اس تحقیق کا مقصد اس بات کا جائزہ لینا ہے کہ پاکستانی نظام صحت میں LHWs کو انفرادی اور اجتماعی طور پر کن تجربات کا سامنا کرنا پڑا۔

☆ اس تحقیق کا مقصد ہے کہ LHWs کے کیونٹی اور اپنے کام کے دوران تجربات کا مطالعہ کیا جائے۔  
☆ اس تحقیق کے نتائج ہیلتھ ورکرز کے بارے میں اہم آگاہی فراہم کریں گے۔  
☆ مجھے اپنی تحقیق کے سلسلے میں ایک رضا کار کی تلاش ہے۔ اور مندرجہ بالا معاملات میں آپ کی مہارت اور علم کی وجہ سے آپ کو اس تحقیق میں شمولیت کی دعوت دی جا رہی ہے اگر آپ اس تحقیق میں شامل ہونے کے لئے راضی ہیں تو آپ سے LHWs کے بارے میں گروپ کی صورت میں بات چیت کی جائے گی۔ جس کا دورانیہ دو گھنٹے سے کم ہوگا۔ آپ بغیر کوئی وجہ بتائے اس تحقیق سے دستبردار ہو سکتے ہیں اور اگر آپ چاہیں تو کسی بھی سوال کا جواب نہ دیں۔  
☆ آپ کے گروپ کی کارروائی ریکارڈ کھائی جائے گی اور آپ اپنی آواز سے پہچانے جاسکتے ہیں۔ مگر آپ کا ریکارڈ کیا گیا انٹرویو یا اس کا کوئی بھی حصہ کسی کو بھی نہیں سنایا جائے گا اور اسے صیغہ راز میں رکھا جائے گا۔ آپ کی طرف سے دی گئی تمام معلومات کو خفیہ رکھا جائے گا۔ اور آپ کے علاوہ اس معلومات تک کسی اور کو رسائی نہیں ہوگی۔ اس تحقیق کو کسی بھی تعلیمی جریدے میں شائع کیا جاسکتا ہے۔  
☆ اگر آپ کسی آزاد فرد سے اس بارے میں رابطہ کرنا چاہیں جو اس تحقیق کا حصہ نہیں ہے۔ تو آپ مسٹر ماجد شہزاد سے مندرجہ ذیل پتے پر رابطہ کر سکتے ہیں۔

ماجد شہزاد : انسٹرکٹر ہیلتھ سروسز اکیڈمی (وزیراعظم ہیلتھ کمپلیکس) چک شہزاد اسلام آباد

ای میل : majid@hsa.edu.pk

ٹیلی فون : 051-9255594

اگر یہ معلوماتی صفحہ پڑھ اور سمجھ کر آپ کو اپنے سوالات کے جوابات مل گئے ہیں اور آپ میری تحقیق میں شامل ہونا چاہتے ہیں تو آپ مہربانی کر کے کانٹ فارم کو دیکھیں۔

نام اور محقق کا پتہ: چوہدری محمد امجد

ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ لٹھین شرقی، ای ایچ ۶۲ یو یو، برطانیہ  
ای میل: achaudhry@qmu.ac.uk

ٹیلی فون: 0519205881 ++441314740000

### آزاد مشیر کی تفصیلات

مشیر کا نام: پروفیسر باربرا میک پیک

ڈائریکٹر

ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ لٹھین شرقی، ای ایچ ۶۲ یو یو، برطانیہ

ای میل: bmcpake@qmu.ac.uk

ٹیلی فون ++441314740000



## Information Sheet for Key Informants



### Information Sheet for Potential Participants

My name is **Chaudhry Muhammad Amjad** I am a PhD student from the **Institute for International Health and Development Queen Margaret University in Edinburgh, United Kingdom**. As part of my PhD course, I am undertaking a research project. The title of my project is: **Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**.

This study will investigate how women trained as Lady Health Workers articulate their work experiences and view themselves as health workers within the Pakistani health system. The objectives of this study are to explore the influence of individual life trajectories of women trained as LHWs and collective experiences of LHWs' as they enter and work within the Pakistani health system. The study envisages to understand how community and workplace-based gender dynamics influences the roles, activities, and working practices of LHWs. The findings of the project will be useful because this will enable better understanding of the LHWs as a health provider's cadre.

I am looking for volunteers to participate in the project and you have been identified as a key informant based on your expertise in the LHW issues. You are welcome to take part. If you agree to participate in the study, you will be asked to discuss issues related to the LHWs. The whole procedure should take no longer than two hours. You will be free to withdraw from the study at any stage and you would not have to give a reason or answer all the questions.

Your interview will be recorded and you may be identifiable from tape recordings of your voice but the recording and your interview contents would not be shared with anyone. The data will be anonymised and your name will be replaced with a participant number, and it will not be possible to identify you in any reporting of the data gathered. The results may however, be published in a journal or presented at a conference or remain unpublished.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Mr. Majid Shahzad. His contact details are given below.

Name: **Majid Shahzad , Instructor**  
Address: **Health Services Academy**  
**Opposite National Institute of Health (NIH)**  
**Chak Shahzad, Islamabad, Pakistan**

Email / Telephone: [majid@hsa.edu.pk](mailto:majid@hsa.edu.pk) 051 9255594

If you have read and understood this information sheet, any questions you have been answered, and you would like to be a participant in the study, please now see the consent form.

Contact details of the researcher

Name of researcher: **Chaudhry Muhammad Amjad**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [achaudhry@qmu.ac.uk](mailto:achaudhry@qmu.ac.uk) / 051 9205881 & ++ 44 131 474 0000

Contact details of the independent adviser (note that the independent adviser cannot be a member of your supervisory team)

Name of adviser: **Professor Barbara McPake, Director**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [bmcpike@qmu.ac.uk](mailto:bmcpike@qmu.ac.uk) / ++ 44 131 474 0000



Queen Margaret University  
EDINBURGH

### کی انفارمیٹ (Keyinformant) انٹرویو کے لیے معلوماتی صفحہ

میرا نام چوہدری محمد امجد ہے اور میں ادارہ برائے بین الاقوامی صحت اور ترقی، کونین مارگریٹ یونیورسٹی، برطانیہ میں پی ایچ ڈی کا طالب علم ہوں۔ میں پی ایچ ڈی کورس کے سلسلے میں ایک تحقیقی کام کر رہا ہوں جس کا عنوان ہے ”پاکستانی لیڈی ہیلتھ ورکرز (LHWs) کی پاکستانی معاشرے میں ذاتی اور پیشہ ورانہ حیثیت“

☆ یہ تحقیق اس بات کا جائزہ لے گی کہ تربیت یافتہ LHWs کس طرح پاکستانی نظام صحت میں خود کو دیکھتی ہیں۔  
☆ اس تحقیق کا مقصد اس بات کا جائزہ لینا ہے کہ پاکستانی نظام صحت میں LHWs کو انفرادی اور اجتماعی طور پر کن تجربات کا سامنا کرنا پڑا۔

☆ اس تحقیق کا مقصد ہے کہ LHWs کے کیونٹی اور اپنے کام کے دوران تجربات کا مطالعہ کیا جائے گا۔

☆ اس تحقیق کے نتائج ہیلتھ ورکرز کے بارے میں اہم آگاہی فراہم کریں گے۔

☆ مجھے اپنی تحقیق کے سلسلے میں ایک رضا کار کی تلاش ہے۔ اور مندرجہ بالا معاملات میں آپ کی مہارت اور علم کی وجہ سے آپ کو اس تحقیق میں کی انفارمیٹ کی حیثیت سے شمولیت کی دعوت دی جا رہی ہے اگر آپ اس تحقیق میں شامل ہونے کے لئے راضی ہیں تو آپ سے LHWs کے بارے میں بات چیت کی جائے گی۔ جبکہ دورانہ دو گھنٹے سے کم ہوگا۔ آپ بغیر کوئی وجہ بتائے اس تحقیق سے دستبردار ہو سکتے ہیں اور اگر آپ چاہیں تو کسی بھی سوال کا جواب نہ دیں۔

آپ کا انٹرویو ریکارڈ کیا جائے گا اور آپ اپنی آواز سے پہچانے جاسکتے ہیں۔ مگر آپ کا ریکارڈ کیا گیا انٹرویو یا اس کا کوئی بھی حصہ کسی کو بھی نہیں سنایا جائے گا اور اسے صیغہ راز میں رکھا جائے گا۔ آپ کی طرف سے دی گئی تمام معلومات کو خفیہ رکھا جائے گا۔ اور آپ کے علاوہ اس معلومات تک کسی اور کو رسائی نہیں ہوگی۔ اس تحقیق کو کسی بھی تعلیمی جریدے میں شائع کیا جاسکتا ہے۔

☆ اگر آپ کسی آزاد فرد سے اس بارے میں رابطہ کرنا چاہیں جو اس تحقیق کا حصہ نہیں ہے۔ تو آپ مسٹر ماجد شہزاد سے مندرجہ ذیل پتے پر رابطہ کر سکتے ہیں۔

ماجد شہزاد : انسٹرکٹر ہیلتھ سروسز اکیڈمی (وزیراعظم ہیلتھ کمپلیکس) چک شہزاد اسلام آباد

ای میل : majid@hsa.edu.pk

ٹیلی فون : 051-9255594

اگر یہ معلوماتی صفحہ پڑھ اور سمجھ کر آپ کو اپنے سوالات کے جوابات مل گئے ہیں اور آپ میری تحقیق میں شامل ہونا چاہتے ہیں تو آپ مہربانی کر کے کانٹ فارم کو دیکھیں۔

نام اور محقق کا پتہ: چوہدری محمد امجد

ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ توہین شرقی، ای ایچ ۶۲۱ یو یو، برطانیہ

ای میل: acaudhry@qmu.ac.uk

ٹیلی فون: 0519205881 ++441314740000

### آزاد مشیر کی تفصیلات

مشیر کا نام: پروفیسر باربرا میک پیک

ڈائریکٹر

ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ توہین شرقی، ای ایچ ۶۲۱ یو یو، برطانیہ

ای میل: bmcpake@qmu.ac.uk

ٹیلی فون ++441314740000

## Consent Form for Lady Health Worker Interview



Queen Margaret University  
EDINBURGH

### **Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

I agree to my interview being recorded.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details of the researcher

Name of researcher: **Chaudhry Muhammad Amjad**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [achaudhry@gmu.ac.uk](mailto:achaudhry@gmu.ac.uk) / 051 9205881 & ++ 44 131 474 0000



Queen Margaret University  
EDINBURGH

### اجازت نامہ برائے لیڈی ہیلتھ ورکر انٹرویو

”پاکستانی لیڈی ہیلتھ ورکرز کی پاکستانی معاشرے میں ذاتی اور پروفیشنل حیثیت“

- ☆ میں نے معلوماتی صفحہ اور اجازت نامہ پڑھ اور سمجھ لیا ہے۔
- ☆ مجھے اس میں شمولیت کے بارے میں سوال کرنے کا موقع دیا گیا ہے۔
- ☆ میں جاننا رہتا رہتی ہوں کہ میں اس کام میں شامل ہونے کی تابع نہیں
- ☆ مجھے معلوم ہے کہ میں اس کام سے بغیر کوئی وجہ بتائے اور کسی بھی مرحلہ پر دستبردار ہونے کا حق رکھتی ہوں۔
- ☆ میں اس کام میں شرکت کے لیے متفق ہوں۔
- ☆ میں اس کام میں دیئے گئے انٹرویو کی ریکارڈنگ پر بھی متفق ہوں۔
- انٹرویو دینے والے کا نام : \_\_\_\_\_

انٹرویو دینے والے کا دستخط : \_\_\_\_\_

محقق کے دستخط : \_\_\_\_\_

تاریخ : \_\_\_\_\_

محقق سے رابطے کی تفصیلات

محقق کا نام : چوہدری محمد امجد

محقق کا پتہ : ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ ٹوٹھمین شرقی، ای ایچ ۲۱ یو یو برطانیہ

ای میل : [achaudhry@qmu.ac.uk](mailto:achaudhry@qmu.ac.uk)

ٹیلی فون : 051-9205881 ++441314740000

## Consent Form for Lady Health Worker participant of focus group discussion



### **Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

I agree to the recording of the discussion.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details of the researcher

Name of researcher: **Chaudhry Muhammad Amjad**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [achaudhry@qmu.ac.uk](mailto:achaudhry@qmu.ac.uk) / 051 9205881 & ++ 44 131 474 0000



Queen Margaret University  
EDINBURGH

## اجازت نامہ برائے ہیلتھ حکام فوکس گروپ ڈسکشن

### (Focus Group Discussion)

”پاکستانی لیڈی ہیلتھ ورکرز کی پاکستانی معاشرے میں ذاتی اور پروفیشنل حیثیت“

- ☆ میں نے معلوماتی صفحہ اور اجازت نامہ پڑھ اور سمجھ لیا ہے۔
- ☆ مجھے اس میں شمولیت کے بارے میں سوال کرنے کا موقع دیا گیا ہے۔
- ☆ میں جاننا چاہتی ہوں کہ میں اس کام میں شامل ہونے کی تابع نہیں
- ☆ مجھے معلوم ہے کہ میں اس کام سے بغیر کوئی وجہ بتائے اور کسی بھی مرحلہ پر دستبردار ہونے کا حق رکھتی ہوں۔
- ☆ میں اس کام میں شرکت کے لیے متفق ہوں۔
- ☆ میں کی گئی ڈسکشن کی ریکارڈنگ پر بھی متفق ہوں
- فوکس گروپ میں شامل ہونے والے کا نام : -----
- فوکس گروپ میں شامل ہونے والے کا دستخط : -----
- تحقق کے دستخط : -----

تاریخ : -----

### محقق سے رابطے کی تفصیلات

محقق کا نام : چوہدری محمد امجد  
محقق کا پتہ : ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگرٹ یونیورسٹی، مسلبرگ ٹوہین شرقی، ای ایچ ۲۱ یو یو برطانیہ  
ای میل : acaudhry@qmu.ac.uk  
ٹیلی فون : 051-9205881 ++441314740000



## Consent Form for Key informant Interview



Queen Margaret University  
EDINBURGH

### **Lady Health Workers in Pakistan: Tracing personal and professional trajectories within a patriarchal context**

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

I agree to my interview being recorded.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details of the researcher

Name of researcher: **Chaudhry Muhammad Amjad**

Address: **The Institute for International Health and Development,  
Queen Margaret University,  
Queen Margaret University Drive, Musselburgh,  
East Lothian, EH21 6UU,  
United Kingdom**

Email / Telephone: [achaudhry@qmu.ac.uk](mailto:achaudhry@qmu.ac.uk) / 051 9205881 & ++ 44 131 474 0000



Queen Margaret University  
EDINBURGH

### اجازت نامہ برائے کی انفارمنٹ (Keyinformant) انٹرویو

”پاکستانی لیڈی ہیلتھ ورکرز کی پاکستانی معاشرے میں ذاتی اور پروفیشنل حیثیت“

- ☆ میں نے معلوماتی صفحہ اور اجازت نامہ پڑھ اور سمجھ لیا ہے۔
- ☆ مجھے اس میں شمولیت کے بارے میں سوال کرنے کا موقع دیا گیا ہے۔
- ☆ میں جانتا رہتا رہی ہوں کہ میں اس کام میں شامل ہونے کی تابع نہیں
- ☆ مجھے معلوم ہے کہ میں اس کام سے بغیر کوئی وجہ بتائے اور کسی بھی مرحلہ پر دستبردار ہونے کا حق رکھتی ہوں۔
- ☆ میں اس کام میں شرکت کے لیے متفق ہوں۔
- ☆ میں اس کام میں دیئے گئے انٹرویو کی ریکارڈنگ پر بھی متفق ہوں۔

انٹرویو دینے والے کا نام : \_\_\_\_\_

انٹرویو دینے والے کا دستخط : \_\_\_\_\_

تحقق کے دستخط : \_\_\_\_\_

تاریخ : \_\_\_\_\_

تحقق سے رابطے کی تفصیلات

تحقق کا نام : چوہدری محمد امجد

تحقق کا پتہ : ادارہ برائے بین الاقوامی صحت اور ترقی کوئین مارگریٹ یونیورسٹی، مسلبرگ ٹوٹھین شرقی، ای ایچ ۲۱ یو یو برطانیہ

ای میل : [achaudhry@qmu.ac.uk](mailto:achaudhry@qmu.ac.uk)

++441314740000

ٹیلی فون : 051-9205881

### **Sample topic guide of potential areas of inquiry for Interviews**

- The life experiences of LHWs before joining NP
- Decision process for joining NP
- Pathways and experiences of transition from novice to a LHW
- Individual positioning and role of LHW within family, community and health system
- Individual changes in expectations and adjustments as a LHW
- Past concerns, current thoughts and future aspirations as LHW
- Positioning of the LHW as individuals and its effect on their work
- Role and influence of household, family, community in work of the individual LHWs outside the home
- Conceptualizations and understanding the work of LHWs as a profession by themselves and other health workers
- Influence of the social system e.g. gender, caste on the individual LHW's career pathways

### **Sample topic guides potential areas of inquiry for FGDs**

- Collective experiences of LHWs in their communities and health system
- Social positioning of the LHWs as groups within community and health system
- Collective positioning and situation of the LHWs within health work force
- Interactions, networks and relationships of LHWs between themselves and the health system
- Influence of the social system e.g. gender, caste in carrying out various activities
- Role of social and organizational power structures on mobility and social networks of LHWs as a collective group
- Challenges and opportunities encountered in on going liaison and bridging gaps between communities and health system

**Field guide for KI interviews**

1. How long have you been associated with the NP and LHWs?
2. In what capacity you are/were associated with the NP?
  - Planning of NP
  - Selection, training, monitoring, supervision of LHWs
  - Other
3. What were your early experiences with the LHWs?
  - Selection, training, monitoring, supervision of LHWs
  - Barriers, difficulties
4. What changes have you observed in the LHWs over the years?
  - Beginning
  - Now
5. What changes have you observed in the various phases of the LHWs?
6. How do the LHWs present themselves as individuals?
  - In their community
  - In their households
  - In health centres
7. How do the LHWs present themselves as a group?
  - In their community
  - In their households
  - In health centres
8. Where are the LHWs placed?
  - In their community
  - In their households
  - In health centres
9. What are the restrictions on the LHWs?
  - In their community
  - In their households
10. How do you see the future of LHWs as health workers?

**Field guide for LHW interviews**

1. What is your name?
2. What is your education?
3. What did you want to become when you were in school?
4. Why and how did you opt to become a LHW?
5. What were your early experiences as a LHW?
  - Selection, training, field
  - Household, barriers, difficulties
6. What are the changes you have observed in yourself after becoming a LHW?
7. What changes do you see in the LHWs of different phases?
8. Where are you placed as a LHW?
  - In community
  - In household
  - In health centre
9. What are the restrictions on the LHWs?
  - In their community
  - In their households
10. What are your achievements as a LHW?
11. How do your household members currently view your work as a LHW?
12. How do you see your future as a health worker?

### Field guide for FGDs with LHWs

1. Why did you opt to become LHWs?
2. What were your early experiences as a LHWs **LHW**?
  - Selection, training, field
  - Household, barriers, difficulties
3. What are the changes you have observed in yourselves as LHWs?
4. What differences do you see in the LHWs of different phases?
5. Where are you placed as a LHW?
  - In community
  - In households
  - In health centres
6. What are the restrictions on the LHWs?
  - In their community
  - In their households
7. How do your household members currently view your work as a LHW?
8. How do you see your future as a health worker?